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ABSTRACT

This participant manual is designed to assist substance abuse prevention specialists in the development of knowledge and skills in implementing community-based programs through an entry-level course. The manual initially concentrates on a basic, generic approach to community work, and reviews course goals and objectives. The nine training modules are detailed in terms of goals, objectives, required materials, exercises, and activities. Figures, worksheets, supplementary materials, and references are provided, along with selected readings and bibliographies. The course materials focus on prevention strategies, knowledge of the community, the development of community support, implementation techniques, and burnout. The course pre-/post-test is provided at the conclusion of the manual. (NRB)

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PARTICIPANT MANUAL

COMMUNITY-BASED PREVENTION SPECIALIST

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**NATIONAL DRUG ABUSE CENTER
FOR TRAINING
AND RESOURCE DEVELOPMENT**

National Institute on Drug Abuse
Division of Training
5600 Fishers Lane
Rockville, Maryland 20857

**NATIONAL INSTITUTE
ON DRUG ABUSE**

**U.S. DEPARTMENT OF HEALTH
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PUBLIC HEALTH SERVICE

*ALCOHOL, DRUG ABUSE,
AND MENTAL HEALTH ADMINISTRATION*

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The National Drug Abuse Center for Training
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PARTICIPANT MANUAL

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INTRODUCTION

RATIONALE AND DESCRIPTION

This Community-Based Prevention Specialist training package represents a revision of the original course, of the same name, developed in 1977, by Shakura A. Sabur of the Southwest Regional Support Center.

The revised course reflects additional resources in prevention needs assessment, planning, and evaluation, developed in the interim, as well as new perspectives on multicultural drug abuse prevention programming. Like its predecessor, the revised Community-Based Prevention Specialist course is designed as an "entry-level" course for any individual designated as the prevention specialist within his or her agency.

The Community-Based Prevention Specialist course is based on the synthesis of the theoretical propositions of Murray Ross (1955), Jack Rothman (1964), and Roland Warren (1966). This generic approach to community organization and community development considers:

- The nature of community
- The various institutional and organizational subsystems that make up a "community"
- Sociopolitical aspects of community life
- The nature and processes of institutional and organizational cooperation in community life, including:
    - Social structure
    - Social processes
    - Boundaries
    - Interface
    - Access
- The processes of intergroup and inter-organizational cooperation
- Roles and responsibilities of the professional in community organization and community work.

After this basic, generic approach to community work has been presented, the course introduces the special knowledge and skills required for understanding and implementing prevention programs, using the community and its diverse subsystems. The subsystems of reference are: the family, schools, religious organizations, social organizations, work organizations, and social welfare organizations, as well as other institutional or organizational subsystems that might be found within the community.

The course is based on the view that planning and implementing any programming activity in prevention, particularly in the area of drug and substance abuse, requires an understanding of the contexts and conditions that are associated with use of drugs and other substances. However, the body of knowledge about prevention of drug abuse is in its early developmental stage, and previous research projects have emphasized attempts to identify early indicators of potential drug and other substance abuse. These attempts have been focused, primarily on the attributes of individuals or instances of behavior that were thought to be associated with drug and other substance use/abuse. Programmatic activities were typically designed to change attitudes, behaviors, or both.

An alternative, although not necessarily competing, point of view, has guided the development of this community-based prevention program. This point of view incorporates the widely held assumption that a significant proportion of drug and other substance abuse is associated with differentials in opportunity to "the quality of life" in a given community. Further, it is assumed that a program characterized by the system-wide (community) definition of a problem, careful planning to address the problem, and opportunities for collaboration in attempts to solve the problem will have a high potential for success. When aspects of community life contribute to problems such as drug abuse, those aspects can be identified in a community assessment process and can then be addressed in an overall prevention strategy.

As NDACTRD's Cross Cultural Adaptation Task Force commented, "Primary prevention for racial/ethnic minorities must include a focus on empowering communities so that the health of their members will be improved. This concept indicates that political and economic issues, as well as personal and social ones, are appropriate subjects for prevention efforts."

The Community-Based Prevention Specialist program leaves the determination of whether a prevention program focused on individual-change or community-change is appropriate for a given community preventor. But, in recognizing that any program must become an integral part of the life of the community in order to succeed, survive, and grow, Community-Based Prevention Specialist seeks to allow community preventors to make their own program choices and also to provide them with critical skills for converting those choices into reality.

GOALS

The overall goal of this course is to provide individuals charged with the responsibility of developing drug abuse prevention activities within their communities with the knowledge and skills necessary to successfully implement such activities. To this end, the course will provide participants with opportunities to gain an understanding of:

- Current drug abuse prevention programs, strategies, and philosophy
- The activities and approaches of NIDA's Prevention Branch
- Resource identification and utilization within the contexts of their own communities
- Needs assessment, planning, and evaluation of drug abuse programs
- National resources and technical assistance opportunities

8

- Their roles as drug abuse preventors
- Future directions in drug abuse prevention.

The course is also designed to develop and enhance participant skills in:

- Interpersonal communication
- Community organization
- Values clarification
- Action planning
- Creative problem solving
- Public relations
- Decision making
- Resource identification and procurement.

OBJECTIVES

At the end of this course, participants will be able to:

- Describe at least five personal strengths and skills that they possess
- List three of their own personal beliefs that shape their attitudes about drug abuse prevention
- Identify the four major components of NIDA's prevention continuum
- Write a one-sentence statement delineating their personal drug abuse prevention philosophy
- Identify at least one current prevention strategy for each component of NIDA's prevention continuum
- Identify the major target areas for drug abuse prevention programs
- List at least five existing prevention programs and describe their general approaches
- List at least three prevention approaches that are consistent with their individual prevention philosophy
- Identify six indicators of "high risk" for adolescent drug abuse
- List at least five of the critical factors that they will consider in developing a drug abuse prevention program for their community
- List the major interest groups in their community

- Develop a profile of their community strengths, resources, and values
- List five factors that promote the acceptance of drug abuse prevention programs in their communities
- List five factors that hinder prevention efforts in their communities
- Write an action plan for creating community support
- List at least three criteria for success in their efforts to build community support for prevention
- Identify the constituent elements of an effective community media campaign
- List the significant communications media in their own communities
- Develop a plan for a media campaign or "drug abuse prevention week" effort
- Identify at least five program planning and development skills they utilized during the training
- Explain the basic concepts of networking
- List at least five community and five external resources that can help them develop effective prevention programs
- Identify at least three personal coping strategies they can utilize for personal growth
- List at least five interpersonal skills practiced during the training
- Take an inventory of the community information and planning methods generated during the training.

MODULE I

MODULE I: INTRODUCTION AND OVERVIEW **TIME:** 3 HOURS 15 MINUTES

GOALS

- Introduce participants and trainers to each other
- Examine individuals' expectations about the course, in terms of design and content
- Share individual strengths and successes.

OBJECTIVES:

At the end of this module, participants will be able to:

- Identify the names and organizational affiliations of at least three other participants and all of the trainers in the course
- List at least three personal strengths and skills that they possess
- Identify the major goal and describe the general sequence of activities of the course.

MATERIALS:

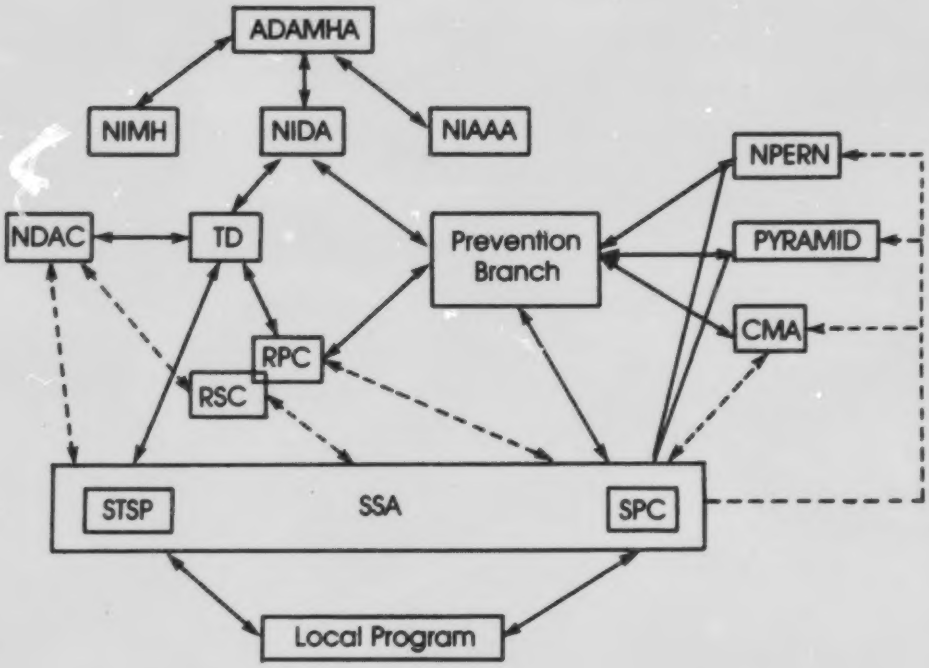
- Registrations Forms
- Pretest Forms
- Pencils
- Newsprint
- Magic markers
- Worksheets: "Strengths and Expectations," "Roles and Responsibilities"

MODULE I OVERVIEW

EXERCISE	TIME	METHODOLOGY
1. REGISTRATION	30 MINUTES	INDIVIDUAL
2. PRETEST	30 MINUTES	INDIVIDUAL
3. TRAINER INTRODUCTIONS	5 MINUTES	TRAINERS
4. NAME GAME	25 MINUTES	LARGE-GROUP EXERCISE
5. GROUP CONTRACT	15 MINUTES	DISCUSSION
6. HOW WE GOT HERE	30 MINUTES	SMALL-GROUP EXERCISE
7. PERSONALIZING THE DATA	30 MINUTES	SMALL-GROUP EXERCISE
8. COURSE OVERVIEW	20 MINUTES	LECTURE
9. SUMMARY	10 MINUTES	LECTURE

Figure I-1

Scheme of the Division of Training and Prevention Branch Programs


ADAMHA
NIMH
NIDA
NIAAA
NPERN
NDAC
TD
Prevention Branch
PYRAMID
CMA
RPC
RSC
STSP
SSA
SPC
Local Program

NOTE: NIAAA funding structures vary from state to state. In some states, NIAAA programs are funded through a separate system, similar to the one depicted here. In others, NIAAA and NIDA programs are both funded through the single system shown here.

ROLES AND RESPONSIBILITIES

NAME	PROGRAM	ROLES	RESPONSIBILITIES
1.			
2.			
3.			
4.			
5.			
6.			
7.			

MODULE 1: INTRODUCTION AND OVERVIEW--2 WORKSHEET

STRENGTHS/EXPECTATIONS

STRENGTHS	EXPECTATIONS
1.	
2.	
3.	
4.	
5.	

INSTRUCTIONS

In the left column, write down five expectations you have about this course--what you might like to see happen, specific things you would like to leave the training with, what you think you came for. To think more reflectively about your expectations, you might complete the sentence, "I'll be really satisfied when I leave this course if. . ."

In the right column, list five strengths or skills you bring to this training. These may be prevention specific (I'm good at values clarification), or organizational (I'm really good at budgets), or personal (I'm a good listener). Think about how a friend or colleague might complete the sentence, "What I really like about you is. . ."

SOME OTHER ICE BREAKER ACTIVITIES

The activities suggested below are generally helpful in at least three ways--

- As ice-breakers
- Aids for the participants to get to know one another
- Help in identifying group members as possible future resources.

And besides, these activities are fun. This list is just a beginning, and the length of your own list will grow with your experiences.

1. Pair Introductions

   Each persons meets and gets to know one other person and in turn introduces his or her partner to the entire group.

2. Dyad and Quartet

   Same as above, but instead of introducing his partner to the entire group, he or she introduces him or her to another dyad.

3. One-Minute Autobiography

   Break into groups of a dozen or so. Each person is given one minute to tell about himself. Use a timekeeper, and don't let anyone go over one minute. Restrictions can be set as to what can be talked about (e.g., nothing about job, family, home town, hobbies). These restrictions enable the participants to get right to attitudes and values.

4. Depth Unfolding Process

   Use this activity in small groups, because it takes five minutes per person. In the first three minutes, tell what has brought you to this point in your life. One minute is used to describe your happiest moment. The last minute is used to answer questions from others. The leader discloses first, to aid in trainee comfort.

5. Structured Introductions

   In dyads, small groups, or in the large group, participants can talk about their happiest moments, write their own epitaphs, write a press release about themselves, etc.

6. Life Map

   Each person draws on newsprint with crayons or magic markers a picture of his life, using stick figures and symbols.

7. Name Circle

Participants sit in a large circle. The leader begins by stating the name of the person seated to his right, followed by his own name. The person to his right repeats the leader's name, his own name, and adds the name of the person seated to his right. This process is repeated around the entire circle.

8. Sandwich Boards

Each person writes on a sheet of newsprint "Things I Know" (about the content and purposes of the training, areas of personal expertise, etc.). On a second sheet of newsprint, he writes "Things I Want to Know." The sheets are joined with tape, sandwich board style, and the participants mill round, nonverbally, identifying resources and getting to know one another.

9. Consensus-Based Group Objectives

Each person privately lists five (the number is optional) personal objectives for the training. He or she shares them with a partner, and they arrive at five. The dyads go to quartets and then to octets. The octets report out their objectives (reached by consensus) and a total-group set of objectives is formulated. This activity can aid in checking the contract and also help obviate the problem of hidden agendas.

10. Sentence Completions

A prepared list of sentences (e.g., "Anyone who smokes in front of his children...") is spun around the group or used in small groups.

A WORD ABOUT: CLIMATE SETTING*

In participatory training, the group atmosphere should encourage honesty and openness. Success depends upon everyone feeling free to actively participate, to comment, to question, to give feedback. Actively listening to others is as important as actively participating in the group. This atmosphere is often referred to as the training "climate."

The training design for Module I is structured to establish a climate conducive to learning through the Name Game structured experience and the Community Reporter expectation exercise.

Immediately after the pretest is concluded and the trainers have introduced themselves, the session opens with the Name Game. This is a fun way of helping participants begin to get acquainted and to feel at ease with each other. It provides each participant with a low-risk experience in speaking to the entire group and establishes an atmosphere in which learning (in this case, people's names) can be an enjoyable process.

The Strengths/Expectations exercise is a structured way of helping participants learn more about each other. It helps participants begin to build relationships with each other by dividing the large group into smaller groups. It facilitates the involvement of individuals in a newly formed group and it allows participants to become acquainted quickly in a relatively nonthreatening way. It also promotes a compatible climate and readiness for interaction within a group through the sharing of personal information.

In the Strengths/Expectations exercise, participants identify some of their expectations about the course. You then use this data to discuss which expectations can and cannot be met through this course. This structured experience helps trainees begin to answer the questions: Who are the other people in this course? What are they like? How are we similar? How are we different?

---

*Adapted from Ann R. Bauman, "Introduction to learning Theory: The Learner." Training of Trainers--Trainers Manual, Rosslyn, Virginia: NDAC, 1977, p. I-15.

MODULE II

MODULE II: PERSPECTIVES ON PREVENTION **TIME:** 3 HOURS

GOALS

- Acquaint participants with the history of drug abuse prevention, current governmental definitions of prevention, and the social and environmental influences on drug use in our society
- Aid participants in discovering their own attitudes and concepts about drug abuse prevention.

OBJECTIVES:

At the end of this module, participants will be able to:

- List at least five social and cultural factors that influence individual drug consumption choices and patterns
- Identify two statements that reflect their own concept of drug abuse prevention
- Identify the prevention definitions currently used by NIDA and other Federal agencies active in drug abuse prevention
- List three major historical events involved in the development of the drug abuse prevention movement in this country.

MATERIALS:

- Newsprint
- Magic Markers
- Definitions of Prevention
- Selected Readings

MODULE II OVERVIEW

EXERCISE	TIME	METHODOLOGY
1. INTRODUCTION/ OVERVIEW	5 MINUTES	LECTURE
2. TO TELL THE TRUTH	45 MINUTES	SMALL-GROUP EXERCISE
3. INFLUENCING FACTORS	20 MINUTES	SMALL-GROUP EXERCISE
4. EXAMINING THE DRUG CLIMATE	30 MINUTES	LECTURE/DISCUSSION
5. HISTORY OF DRUG ABUSE PREVENTION	25 MINUTES	LECTURE/DISCUSSION
6. THE CONCEPT OF PREVENTION	15 MINUTES	LECTURE/DISCUSSION
7. DEFINITIONS OF PREVENTION	30 MINUTES	LARGE-GROUP EXERCISE
8. REVIEW/PREVIEW	10 MINUTES	DISCUSSION

DRUG ABUSE PREVENTION

AN OPERATIONAL DEFINITION OF DRUG ABUSE PREVENTION

The fundamental objective of drug abuse prevention is to assist youth to develop and mature into healthy productive members of our society. Toward that end, prevention involves the process of "enablement," in which prevention professionals, lay-persons, family members and friends who are concerned, help youth create positive attitudes, values, behaviors, skills and lifestyles that will enable them to mature into happy and competent citizens who need not resort to the use of drugs. The desired outcome of prevention programs is the reduction, delay, or prevention of drug use behavior that is not within the parameters of medical therapy and that disrupts the normal developmental life cycle leading to human competency.

Over the last five years, the concept of drug education has expanded beyond programs that provide youths information or advice concerning drugs and their use. The current conceptual framework for drug abuse prevention programming at NIDA that has evolved from the many prevention programs currently operating at the State and the community level. This framework for prevention operationally defines drug abuse prevention along a continuum of health care programs. The four prevention modalities are information, education, alternatives and intervention programs, with each program type best serving youth at different stages of the drug abuse problem. Treatment and rehabilitation programs complete the continuum and focus upon the drug addict and the recovering drug abuser./l/

Prevention Modalities are defined as follows:

> Information Modalities--Approaches that involve the production and/or distribution of accurate and objective information about all types of drugs and the effects of those drugs on the human systems. Examples include drug information seminars, pamphlet development and distribution.
>
> Education Modalities--Approaches that focus on skill building through use of well-defined and structured affective learning processes. Examples of skills that are to be enhanced include values clarification and awareness, problem solving, decisionmaking, coping with stress, and inter-personal communication. The affective learning processes that are used focus on helping people who may be deficient in the above mentioned skills, but may also serve to reinforce already existing skills. Examples include role playing, peer facilitation, and cross-age tutoring.

/l/Bukoski, Dr. William J., "Drug Abuse Prevention: A Meta-evaluation Process," paper presented at the American Public Health Association Conference, November 4-6, 1979.

Alternatives Modalities--Approaches that provide growth-inducing experiences through which individuals develop increased levels of confidence and self-reliance. Enhancement in these areas is provided through social, occupational, esthetic, affective, and cognitive experiences. Alternatives-based activities are designed to provide exposure to a variety of rewarding activities that offer positive alternatives to drug-taking behavior. Examples include human service delivery in the community, restoration, conservation, and preservation of the environment.

Intervention Modalities--Approaches that focus on the reduction, elimination, and/or delay of drug use, drug use-related dysfunctional behavior, and other problem behaviors prior to onset of serious, chronic, debilitative behaviors. These prevention approaches are able to provide assistance and support to people during critical periods in their lives, when person-to-person communication, sharing of experiences, and empathic listening could contribute to a successful adjustment of a personal or family problem. Examples include professional counseling, rap sessions, and peer counseling.

Prevention settings are defined as follows:

School settings are those in which the major percentage of activity takes place within a school system, and where there are direct linkages to, and involvement with, school officials and functions, often during normal school hours.

Occupational settings are those in which the activities take place in an organization that has legal status as a profit or non-profit making corporation, partnership, or other formally-defined income-generating entity.

Family settings are those in which the major focus is on strengthening family relationships. The family is seen as the group through which the desired outcomes should be addressed.

Community settings are those in which the majority of activities are provided under community auspices, and are concerned with activities which impact on both individuals and the community as a whole. /2/

/2/NIDA, Prevention Branch, "State Prevention Coordinator Grant Program Guidelines," May 1980.

DEFINITIONS OF PRIMARY PREVENTION

1. "Primary drug abuse prevention is a constructive process designed to promote personal and social growth of the individual toward full human potential and thereby inhibit or reduce physical, mental, emotional or social impairment which results in or from abuse of chemical substances."

   - the NIDA Drug Abuse Prevention Delphi, 1975.

2. "The purpose of prevention is to increase the likelihood that individuals will develop drinking-related behaviors that are personally and socially constructive. Negatively stated, prevention programs are aimed at reducing the number of persons whose alcohol-related behavior adversely affects the way they carry on the roles and responsibilities of everyday living."

   - from *Planning Prevention Programs*, National Center for Alcohol Education

3. "Primary prevention of drug abuse is a constructive process designed to promote personal, social, *economic and political* growth of the individual toward full human potential; and, thereby, inhibit or reduce personal, social, *economic or political* impairment which results in or from the abuse of chemical substances."

   - the Center for Multicultural Awareness, a project of NIDA's Prevention Branch

4. "Primary prevention encompasses those activities directed at specifically identified vulnerable high-risk groups within the community who have not been labelled as psychiatrically ill and for whom measures can be undertaken to avoid the onset of emotional disturbance and/or to enhance their level of positive mental health. Programs for the promotion of mental health are primarily educational rather than clinical in conception and operation with their ultimate goal being to increase people's capacities for dealing with crises and for taking steps to improve their own lives."

   - Stephen E. Goldston, Ed.D., Coordinator for Primary Prevention Programs, National Institute for Mental Health

5. "The Alcohol, Drug Abuse, and Mental Health Administration (ADAMHA) requires the description of two types of behaviors - behavioral antecedents and consequences - which are useful in designing primary prevention activities, particularly with regard to health promotion and disease prevention.

   - Prevention of behavioral antecedents refers to interventions to reduce high risk behaviors such as teenage drinking, smoking and experimental drug use, which increase the probability of developing physical, emotional and behavioral problems.

   - Prevention of behavioral consequences refers to interventions to prevent the deleterious effects (consequences) of high-risk behavior, such as accidents resulting from drinking while driving, or suicides or homicides resulting from emotional disorders, excessive drinking, or substance abuse.

- ADAMHA Prevention Policy Paper, August 17, 1979

6. "An aggregate of community education and social action programs which within an identified length of time and for specified groups of people, are able to measureably reduce the likelihood, frequency, seriousness, or duration of chemical use problems by means other than referral or recourse to the chemical dependency treatment system or correctional services."

- (The content of this definition was developed by the Michigan Office of Substance Abuse Services prevention staff.)

7. Primary prevention of social and behavioral problems is accomplished through ongoing processes that provide opportunities for individuals, small groups and organizations to increase: 1) knowledge or awareness of personal and collective potentials; 2) skills necessary to attain those potential; and 3) creative use of resources to the end that all people have the ability to effectively cope with typical life problems and recognize, reduce or eliminate unnecessary or debilitating stress in the community without abusing themselves or others and prior to the onset of incapacitating individual, group or organizational problems.

- (The content of this definition was developed by the Human Services Training Institute, Michael B. Winer, Association Director, Spokane, Washington.)

8. Prevention includes purposeful activities designed to promote personal (emotional, intellectual, physical, spiritual, and social) growth of individuals and strengthen the aspects of the community environment which are supportive to them in order to preclude, forestall, or impede the development of alcohol and other drug abuse problems.

- Wisconsin State Drug Abuse Plan

9. Another way to break down the concept of health promotion is to consider the community as well as the individual. We are accustomed to think of an individual's health, both in terms of treatment and building resistance, but we can extend this to the community. Often people succumb to ill health in part as a result of forces in the social context. Such could include unemployment, insensitive institutions, including schools, or prevalent attitudes which reinforce unhealthy behaviors. If this is the case, then it makes sense to design programs which deal with these factors.

- Vermont Alcohol and Drug Abuse Division

10. The National Association of Prevention Professionals' defines prevention as a proactive process utilizing an interdisciplinary approach designed to empower people with the resources to constructively confront stressful life conditions.

MODULE II: PERSPECTIVES ON PREVENTION--1 **SELECTED READINGS**

PREVENTION OF SOCIAL AND BEHAVIOR PROBLEMS

Prepared by
Dr. Richard Ingraham
Center for Primary Prevention

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PREVENTION OF SOCIAL AND BEHAVIORAL PROBLEMS

DEFINITION:

Primary prevention of social and behavioral problems is accomplished through ongoing processes that provide opportunities for individuals, small groups and organizations to increase: 1) knowledge or awareness of personal and collective potentials; 2) skills necessary to attain those potentials; and 3) creative use of resources to the end that all people have the ability to effectively cope with *typical* life problems and recognize, reduce or eliminate *unnecessary* or debilitating stress in the community without abusing themselves or others and prior to the onset of incapacitating individual, group or organizational problems.

CLARIFICATION:

Primary, as compared with secondary which is early identification and intervention in ongoing problems or tertiary, which is treatment, rehabilitation, and correction of the disabled after a problem has reached incapacitating levels, is delivering knowledge and skills to "normal" people so that they can keep themselves "normal".

Social and behavioral problems include all types of individual and collective problems such as alcohol and drug abuse, crime and delinquency, feelings of inadequacy, family and organizational conflicts, etc.

Individuals, small groups and organizations refers to all people in the community in all of their individual and collective roles; e.g., person, parent, worker, employer, leader, child, etc.

Increase means that at no time in one's life does anyone have all of the information, skills and experience either necessary or sufficient to understand and cope with the ever changing world around them, and we consequently need to actively seek and promote continued growth and awareness.

Knowledge and awareness refers to written, verbal and visual information and ideas in all possible forms as well as every possible tactile, visual, auditory or other sensory, and situational experience that is potentially available to the individual, small group or organization.

Personal and collective potentials refers to the full range of psychological, physiological, and social experience already known and yet to be developed or discovered by man to achieve individual independence and realize mutual responsibility (independence and responsibility).

Necessary skills refers to going beyond the information or cognitive level to assure that each person has the opportunity for demonstration, practice to the level of confidence necessary to be able to successfully act on those things one is aware of, knowledgeable about or discovers in their environment.

Creative use of resources refers to the broadest possible awareness of what is and is potentially available in one's environment and the abilities necessary to increase the probabilities of discovering or creating new resources.

Effectively cope means a successful, meaningful or functionally active approach to typical and atypical experiences encountered during the course of one's life.

Typical life problems refers to those life stresses and experiences that we understand to regularly be a part of one's life cycle for all people or for particular cultural situations and which in essence gives life meaning; e.g., birth, death, love, rejection, discovery, loss, etc.

Unnecessary or debilitating stress refers to processes or experiences encountered in one's environment which most people are not equipped to cope with, or which are not required for successful functioning and in some respect is out of control to the degree that it is abusive.

Without abusing themselves or others means that in the process of increasing the knowledge and skills of ourselves and others or reducing or eliminating stresses in the community, we don't abuse ourselves or others by creating unnecessary stress.

Prior to the onset of incapacitating problems means that unlike treatment, diversion or early identification processes, primary prevention processes deliver information, skills, experiences and alter unnecessary incapacitating processes while people are still relatively unaffected by problems to the degree that they are already manifesting dysfunctional behavior, e.g., throughout the developmental process, via the media, and through every available mode of delivery to the broadest population.

PRIMARY PREVENTION: SOME DEFINITIONS

Introduction

It is difficult to discuss a concept such as Primary Prevention when confusion exists about the language used to examine that concept. The following is an attempt to provide additional information about some of the terminology that has recently been used in dialogue about Primary Prevention.

The definitions provided in this paper are not intended to be absolutes. Each of the terms should be viewed as an evolving idea which changes as new information is gathered and added to what we already believe or know. It should also be kept in mind that a person who is beginning to explore these terms needs more than can be provided by the written word. Exposure to workshops, seminars, or other situations in which the ideas behind the terms can be practiced as well as discussed is an important aspect of developing an individual's concept of each term.

A relatively brief explanation of each term is provided below. At the end of the section on definitions is a reference section which provides additional reading material if an individual is interested in exploring each term in greater detail.

Terms

Positive Human Growth And Development

Human growth and development has been defined by the authors of the School Health Education Study as, "A dynamic life process by which the individual is in some ways like all other individuals, in some ways like some other individuals, and in some ways like no other individual. Growing and developing represents the evolving of the continuous life process from conception to death, with all the attendant changes. Understanding this process is fundamental to the conceptualization of health. It represents a dynamic interplay of the physical, the mental, and the social aspects of the individual."

Positive human growth and development is an emphasis on studying and experiencing those factors of living which enhance the individual in all dimensions. This is a different approach than has been used in the past. Most emphasis has been placed on studying factors which create problems.

An example of the old approach is a study of mental health where the young person explores various forms of mental illness. A *positive* approach to the same topic would emphasize a study of emotions and how they can be used to greatest advantage. Such an approach would also allow the individual to explore ways in which mental capacities could be developed to their maximum potential.

Similar examples of positive approaches to human growth and development can be related to other health areas. Physical growth can be enhanced more by learning what to do rather than what not to do. Social development is enhanced when positive experiences of social interaction are provided.

Decision Making

People are faced with many life situations in which decisions must be made. Decision making is something everyone does every day. Because it is a common act, it receives little attention until a person is faced with an important decision that has long-term consequences.

Although the schools attempt to help students learn how to make personally satisfying decisions, a major portion of a teacher's time involves developing information or supplying it to students. Although extremely important, obtaining information is only *one* segment of the decision-making process. A question that should be asked is, "If you are going to provide information to others, what do you want them to do with that information?" We should provide opportunities for young people to put information to use.

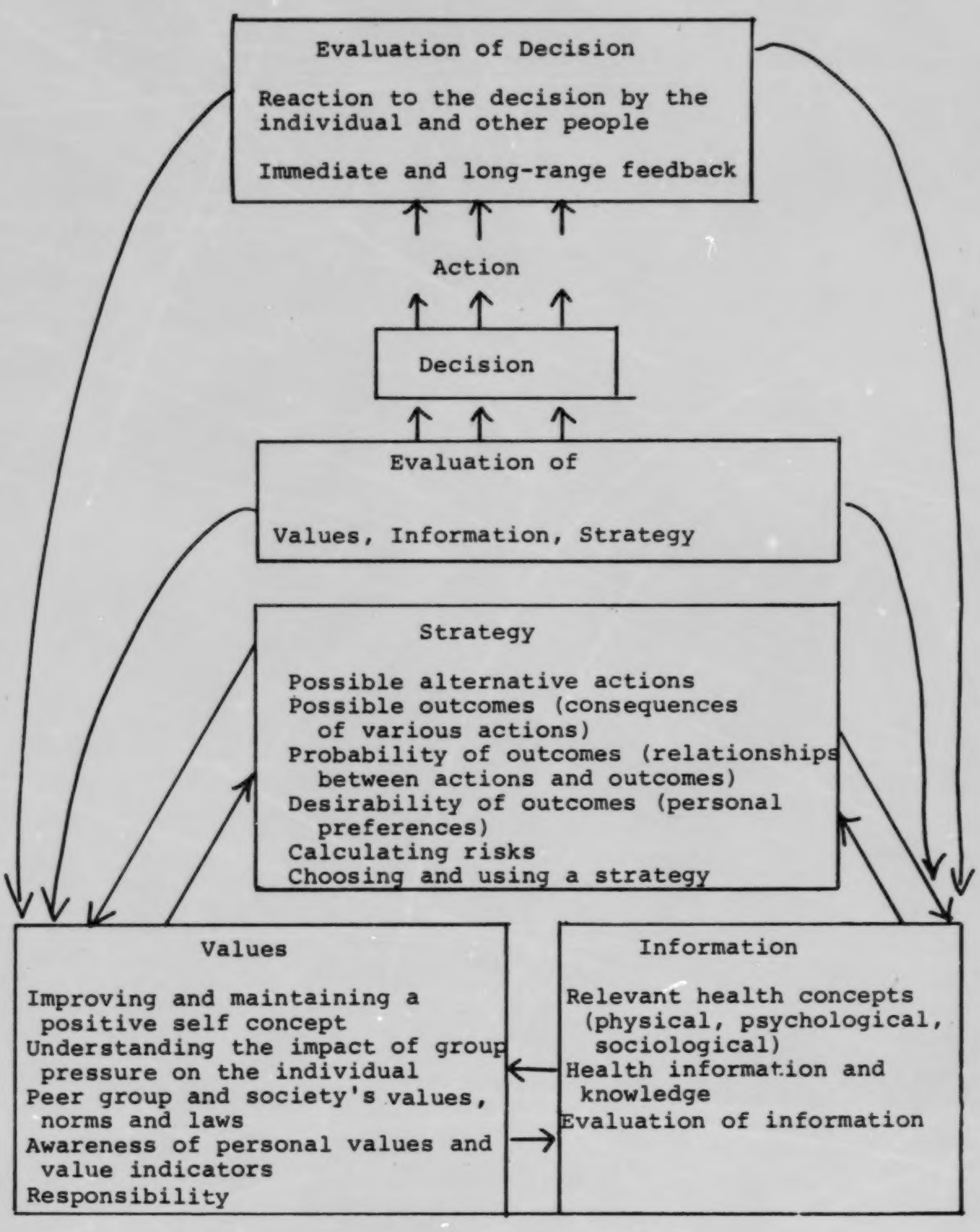
Decision making can be defined as a process in which a person selects from two or more possible choices. A decision does not exist unless there is more than one course of action, alternative, or possibility to consider. If a choice exists, the process of deciding may be utilized. Decision making is unique to man and enables the individual to reason through life situations, to solve problems, and, to some extent, to direct behavior.

There are no "right" answers or outcomes for the decision made, but rather the decision is judged on an effective use of a process that results in satisfying consequences. This distinguishes decision making from problem solving. Problem solving usually identifies one best or right solution for everyone involved.

A skillful decision maker has greater control over his life because he can reduce the amount of uncertainty in his choices and limit the degree to which chance or his peers determine his future. Two individuals may face a similar decision, but each person is different and may place differing values on outcomes. It is the individual who makes each decision unique. Learning decision-making skills, therefore, increases the possibility that each person can achieve that which he values. Decisions also have limits. Each decision is necessarily limited by what a person is capable of doing, by what a person is willing to do, and by the environment in which the decision is being made.

Since decision making is a process which can be carried out if an individual possesses certain skills, it is imperative that opportunities be provided by the family, school and community for individuals to acquire and utilize those skills: (a) data gathering, (b) organizing and analyzing data, (c) identifying alternative choices, (d) weighing the consequences (positive and negative) of each choice, (e) selecting the most appropriate choice, and (f) evaluating the results of acting upon the selection made. Important to the development of these skills is the environment in which they are practiced. A non-judgmental atmosphere would seem most appropriate. Since there is no "right" answer, the person making a decision should be free to select from any of the choices available. (See chart on the following page.)

DECISION MAKING AS IT RELATES TO HEALTH INSTRUCTION


Evaluation of Decision
Reaction to the decision by the individual and other people
Immediate and long-range feedback
Action
Decision
Evaluation of
Values, Information, Strategy
Strategy
Possible alternative actions
Possible outcomes (consequences of various actions)
Probability of outcomes (relationships between actions and outcomes)
Desirability of outcomes (personal preferences)
Calculating risks
Choosing and using a strategy
Values
Improving and maintaining a positive self concept
Understanding the impact of group pressure on the individual
Peer group and society's values, norms and laws
Awareness of personal values and value indicators
Responsibility
Information
Relevant health concepts (physical, psychological, sociological)
Health information and knowledge
Evaluation of information

Value Clarification

Values have been said to be deep, long-lasting commitments to a concept or doctrine that is highly prized and about which action will be taken in satisfying ways. Values give direction to life and may be considered to be determinants of behavior.

Value clarification is a process which involves a series of strategies or methods for helping the individual identify his own values. This includes providing a variety of meaningful experiences and interaction with the environment. Experiences and interactions should be provided in the following:

Choosing:

1. Choosing freely - individual should not be coerced and should have freedom of selection.

2. Choosing from alternatives - a variety of alternatives must be provided.

3. Choosing thoughtfully - consideration should be given to the consequences of each alternative.

4. Affirming - when something is cherished, it is publicly and verbally supported; doing something.

Prizing:

5. Prizing and cherishing - choice has a positive tone and is held in high esteem.

Action:

6. Acting upon choices - life is affected through reading, spending money, and budgeting time.

7. Repeating - persistency and endurance become a pattern of life.

Risk-Taking

It is human to seek more from life than merely remaining alive. There is a never-ending search for satisfaction in living. As we seek answers to the questions about what will bring us satisfaction we do not have absolute answers. Therefore, there is an element of risk in each decision we make about living.

We cannot live without "taking chances." But as intelligent beings, we should be able to weigh possible injury against possible gain and decide whether a risk is worth it.

A study of risk-taking behavior indicates that taking chances is closely tied to an individual's skills in using the decision-making process. Personal values also determine how willing the individual is to take risks. For these reasons, the bibliography on risk-taking has been incorporated into the decision-making and value-clarification sections at the end of this paper and are not dealt with separately.

The four kinds of risks:

- the risk one must accept
- the risk one can afford to take
- the risk one cannot afford to take
- the risk one cannot afford not to take

Druker

Communication

Like many other terms used to deal with an understanding of human beings, communication has many meanings to many people. There are different theories advanced to explain the term communication or the process of communicating.

One of these theories is the Helix theory. This theoretical outlook sees communication as an ongoing process, that once started cannot be reversed. It is basically a stimulus-response sequence where the stimulus can be anything from a personal need to a spoken word. This sequence can be broken down into the following behaviors: thinking - speaking - listening - watching or reading - understanding - integrating - responding. Thus a breakdown in communication can take place at any of the stages, especially at the speaking, listening or interpretation levels. Communication, according to this theory, is not limited to oral interaction. Communication also involves physical and written elements. This theory is an other-oriented one. That is, how a stimulus is interpreted by another will dictate the sequence and outcome of the communication. All previous communications will flavor or effect all future communications.

The Northwest Regional Educational Laboratory, Portland, Oregon has developed a number of training packages dealing with communication. The following is information from one package:

What is communication: Webster indicates it is an act or instance of transmitting. It may also be information communicated, as in verbal or written messages. Or it may be interpreted to be a process by which meanings are exchanged between individuals through a common system of symbols.

Whatever definition is chosen, it is evident that communication involves transmission from one individual to another or to a group. Therefore, any cooperative effort or group enterprise is dependent upon its communication efficiency. Communication efficiency, in turn, depends on content (are the necessary elements of information included) and on process, the way the communication takes place.

One important aspect of the way communication takes place is direction, that is, one way or two way. One way communication includes directives, memos, newspapers, and television commercials. With two-way communication the receiver has the opportunity to communicate with the sender.

The problems of communication are increased by the "static" or "noise" which enters in the transmission. A variety of interpretations may well result from interruptions straying from the topic, or straying minds within the receiver group. Often repetition is the only way for clarification to be obtained. The message then can be completed even if the extraneous factors are present.

Communication patterns are affected by many things -- by past history and tradition, by attitudes toward participation, by norms about what is proper to talk about when, by inter-personal relations and who talks with whom, by how much trust and openness there is, by how skillful people are. Patterns are also shaped by the physical environment -- do meeting rooms encourage one or two-way communication, e.g. are the chairs movable or fixed? Do lounges or dining rooms stimulate sociability? Do living and transportation conditions encourage after-work relating? What forces outside the work area have an impact on communications within the building?

Diagnosing communication requires a look at what behaviors are facilitating and hindering. Illustrations of facilitating behavior might include careful listening, participating freely, providing information, defining unclear terms, asking questions, giving own opinion, suggesting alternatives, or relieving tension. Inhibiting behaviors might include talking too much, not listening to others, withdrawing whenever there is a problem or ridiculing and refusing to consider alternatives.

Communication is, in summary, a complex interaction between people. There are several sub-skills involved in becoming an effective communicator. This suggests that communication is a life-long task requiring continual growth. One cannot become skilled in this area without constant practice of all of the sub-skills involved.

Self-Concept

Self-concept is simply defined as the perception an individual has about himself physically, mentally and socially. That is, being able to answer the questions, "Who am I?" and "Who am I in relation to others?"

Self-concept is enhanced when the individual has a strong, positive self-image, a feeling of belonging and a sense of worth. These things can be fostered by providing activities which focus on the following themes:

1. A child recognizes the many "me's" yet realizes he is unique.

2. A child feels loved and can love.

3. A child is able to cope with anger, fear, sadness and happiness.

4. A child likes to function in a group, yet is comfortable being alone

5. A child likes to do many things.

6. A child relates to the world about him.

We are all interested in ourselves. Realizing this phenomenon, educators recommend that learnings in school be related to the life experiences of the learner. It then seems to follow that with the learner himself the topic of study, the efficiency and effectiveness of the learning process would be maximized.

The question of the appropriateness of oneself as a topic of study within the school setting, however, remains. Since one behaves on how one perceives reality rather than upon reality itself, one's perceptions of oneself will determine many health-related behaviors. For example, one possessing a positive self-concept might be expected to walk tall (upright) while one with a negative self-concept might walk slumped over to physically indicate "lowliness"; or one with a positive sense of sexual self-esteem might be outgoing and pleasant, whereas one with a negative feeling about oneself sexually might behave in a shy, withdrawn manner.

Social Interaction

The social environment consists of people. Learning more about "myself" and those about me . . . learning about human behavior . . . this is what SOCIAL SKILLS are all about.

"Interacting is the dynamic relationship of the individual to the physical, biological, and social world. Their process is in a continual state of flux and interacting may bring about balance or may disrupt the stability of the relationships."

Social interaction is important in studying all health problems. Drug abuse is an example. Because the abuse of drugs is a form of behavior, it follows that the child should begin to discover and learn about the dynamics of his behavior and that of others, not only as it relates to the use of drugs, but also to his own unique role as a social being. He can be led to a deeper understanding of the motivating forces that operate in human behavior.

A variety of social interactions is essential to each child in their everyday living situations. But are we providing a variety of positive, meaningful learning situations to enable the child to be a socially effective child?

What are some of the general principles which would define the socially effective child? We might include that the child:

- understands that his behavior can produce positive or negative feelings in another person.
- recognizes and believes in the importance of accepting the responsibility for the effects that his behavior has caused in someone else.
- realizes that everyone is very much alike in that we have the need for attention, acceptance, approval and affection . . .
  - - as well as the fact that we all have fears and angers that sometimes appear . . . and

- - negative aspects of disappointment, rejection, and frustration which enter our lives.*

Coping

Coping is the ability to fight or contend successfully or on equal terms. It also might be stated as the ability to deal with problems.

Learning to cope with life's problems is dependent upon the individual's knowledge of self, decision-making skill, ability to clarify values and an ability to relate to others. These are skills that have been discussed earlier in this paper.

If we were interested in helping people learn coping skills, we would be doing everything we could to help those people grow and develop as total human beings.

Human Sexuality

Sexuality is an intrinsic part of being human, involving one's understanding and appreciation of oneself as a woman or a man. It is not essentially genital. Sexual activity feels good to most people most of the time and when it involves another can lead to rewarding interpersonal intimacy, as well as to procreation. Reproduction is an important result of sexuality, and ideally is a conscious decision of two people able and willing to undertake a long-term commitment to child rearing. So, sexuality, lovemaking and babymaking are all different things.

Conclusion

It seems fairly obvious that the terms defined in this section are really not mutually exclusive. There is good reason to believe that some, if not all, of the concepts discussed are dependent on each other.

One concept cannot be explored or studied without involving the other concepts. The following bibliography reflects this conclusion in that the resources identified generally deal with more than one topic.

* Basic principles adopted from the writings of Dr. Harold Bessell.

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WHAT SHOULD BE DONE:

FINDINGS OF THE NIDA PREVENTION DELPHI

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WHAT SHOULD BE DONE: FINDINGS OF THE NIDA PREVENTION DELPHI

The types of activities or processes the Delphi II participants felt would serve to operationalize the goals implied by the definition of primary prevention fall into three categories:

- Direct Services to Clients - These were direct responses to conditions manifested in an individual; for example, counseling, training, opportunities for alternative activities.
- Brokerage of Resources - Those processes which assist other formal and informal client-serving programs to make better use of their resources; for example, expanding their awareness of problems and the resources or techniques for addressing them; operating demonstration models of new techniques for or within other agencies until public acceptance is gained; fostering cooperation and collaboration among agencies.
- Facilitative Services - Those services directed to drug abuse prevention, treatment and rehabilitation programs that enable them to utilize more effectively the resources available to them. Many of these services are aimed at the personnel who operate the programs through the provision of information, training and technical assistance.

The list of constructive alternatives below is not meant to be exhaustive. It represents a combination of the activities that participants felt to be most important and can adequately serve to depict the nature and scope of activities that can be encompassed within the parameters of primary prevention:

Direct Client Services

(1) Help youth and young adults to develop awareness, coping, and decision-making skills.

(2) Provide target populations with opportunities for experiences which are as attractive and satisfying as, or more attractive and satisfying than taking drugs (alternatives).

(3) Help persons develop their own alternatives.

(4) Offer family system support services. (Note: Since the family may be seen as a client as well as an institution, this constructive process will appear on both lists.)

Brokerage of Resources

(1) Help schools and communities become more responsive to the rights and needs of youth and other persons within the community.

(2) Offer services that reinforce ongoing and informal groups that provide support for individuals.

(3) Develop a prevention advocacy program directed toward local, state and federal legislatures.

(4) Educate the helping professions concerning need for cooperative modalities in primary prevention.

(5) Offer programs which reinforce family systems support services.

(6) Develop programs to raise public awareness about the misuse of licit (over-the-counter and prescription) drugs.

(7) Encourage the re-examination and re-evaluation of public school athletics and academic grading/success criteria.

(8) Develop and initiate model demonstration projects which are responsive to community needs.

Facilitative Services

(1) Solicit, fund, monitor, evaluate and report results of innovative replicable program.

(2) Provide training to NIDA, other federal agency and SSA personnel in resource identification and brokerage techniques.

(3) Provide a broad-based, flexible technical assistance network available to state and local program managers.

(4) Develop an effective communications network to promote awareness, actions, and information sharing among preventors.

(5) Facilitate the convening of primary preventors for sharing and updating the state of the art.

Summary: What Should The Preventor Do?

From the Delphi I and II data it is possible to draw a composite picture of the kinds of behavior that local, state, and federal preventors enter into as they work toward the goals of primary prevention. All of the actions described below are feasible, in fact are presently being done, although they may not be occurring at the same site. The words and ideas are those of the primary prevention constituency. They are not presented in any rank order because they represent a composite response.

What Does the Local Preventor Do?

- Assists young to develop skills and experiences which tend to make the satisfaction from drugs less potent.
- Mobilizes various community forces to deal with the causative, rather than the symptomatic, factors of drug abuse.
- Develops broad base of community support.
- Operates a sensible system of communication (formal or informal) to the people in the regular human service agencies who must make the actual adjustments in institutional relationships and procedures.
- Helps people take responsibility for their own lives (both target groups and staff).
- Ensures client and community representatives in decision making.
- Recognizes the temporary nature of the primary prevention "system". Does not get involved in empire building.
- Keeps focus on positive human growth rather than drugs.
- Works with people in drug treatment rehabilitation, law enforcement to develop coherent programs.
- Utilizes information collection and management processes to remain sensitive to the differential needs and changing requirements of the population.
- Brokers difficult institutional changes through the rubric of drug prevention.
- Models the processes of communication and interpersonal behavior he wants in others.

Findings: Specific Activities and Management Roles

In addition to suggesting what should be done, the Delphi participants constructed a schema of local, State and Federal management roles intended to demonstrate how personnel at these three levels can coordinate their activities in pursuit of shared primary prevention objectives.

Within Each of the Above-mentioned Program Categories, Local Prevention Brokers and/or Program Managers would:

- assess the problem
- assess available resources
- set a planning process in motion
- insure community involvement
- identify the target group and program participants
- involve the target group in all phases of program planning, implementation and evaluation
- develop a sound and concise proposal
- identify funding sources
- secure adequate support for the overall plan
- prepare a detailed, systematic program design which could be clearly understood by staff, program participants, and program monitors
- identify and make use of the resources of other social agencies and institutions in coordinating an overall program strategy
- assess the need for a special program or programs for minorities in the target community and coordinate the implementation of these programs
- establish procedures for continuing review of program activities, including feedback from program participants and staff
- provide for ongoing evaluation of desired program outcomes
- utilize appropriate media approaches to assure that the community is kept aware of the existence and intent of the program

Within Each of the Above-mentioned Program Categories, Single State Agency Offices would:

- set program guidelines and make them available to local prevention brokers/program managers
- provide assistance to local prevention brokers/program managers in priority setting, planning and identification of resources
- be sensitive to the need for minority and special groups programming
- fund pilot programs

- provide access to state and federal training and technical assistance resources
- conduct workshops for professional and para-professionals in prevention program techniques
- promote coordination at the state level of related social institution support
- maintain an information-sharing network on the state level
- assist local program personnel in the development of effective evaluation methodology
- channel local needs analyses, client feedback and successful program models to the federal level
- take an active role in promoting constructive state legislation in the primary prevention area

Within Each of the Above-mentioned Program Categories, Federal Prevention Agencies would:

- set prevention policy guidelines designed to shape an effective SSA response
- collect and disseminate to SSA's and other relevant support agencies those federal program guidelines and grant notifications which relate to primary prevention objectives
- provide to state and local prevention personnel training and technical assistance for program planning and implementation
- provide demonstration funding for pre-service and in-service teacher training programs designed to impact the primary prevention clientele
- fund local demonstration programs
- establish guidelines for minority and special groups programming
- enlist and coordinate the support of related social service agencies and institutions in the development and implementation of a national primary prevention strategy
- develop and disseminate materials which will (a) promote the understanding of primary drug abuse prevention as a reinforcement of positive human behavioral change; and (b) guide local prevention practitioners in effective program planning and implementation
- facilitate the sharing of useful information and experience among all levels of primary prevention planning and programming
- take an active role in promoting constructive federal legislation in the primary prevention area
- develop evaluation criteria and techniques appropriate for measuring the effectiveness of primary prevention programs

THE CONCEPT OF PREVENTION AND ITS LIMITATIONS*

Prepared by

Richard Brotman, Ph.D.

and

Frederic Soffet

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THE CONCEPT OF PREVENTION AND ITS LIMITATIONS

Although the United States has frequently been characterized as a drug-oriented society, the use of certain drugs for purposes of pleasure or stress relief has, historically, been socially and legally proscribed. Drugs subject to proscription have included heroin and other opiates, cannabis preparations such as marihuana and hashish, LSD and other psychedelics, cocaine, and amphetamines and barbiturates when not used under medical supervision.

Broadly speaking, the proscription has two main sources. First, the use of such drugs is seen as potentially injurious to the physical and mental health of the user, particularly when use is immoderate. Second, their use, especially for reasons of pleasure, has been widely regarded as antithetical to the complex of moral values, including industriousness and maintaining control of one's rational faculties, often designated by the terms "work ethic" or "Protestant ethic." The former assertion hardly requires elaboration. Evidence for the latter may be found in many places, most recently in a survey of a national sample of adults sponsored by the National Commission on Marihuana and Drug Abuse. The survey revealed, for example, that 59 percent of the respondents thought marihuana use makes people lose their desire to work, and 64 percent said using marihuana is morally offensive.[1]

Historically, the loci of responsibility for enforcing the proscription, that is, for the control of illicit drug use, developed initially in two main institutional realms--law and medicine. Stated briefly, the intended function of legal control has been to deter the use and distribution of banned drugs by threat of punitive sanctions. The intended function of medical control, as expressed through various approaches to treating drug users--chemotherapy and therapeutic communities, for example--has been to terminate individual drug use careers. However, as the so-called drug explosion of the 1960s showed, both forms of control largely failed. The law apparently did not deter many persons from becoming involved in illegal drug activities, probably because the risk of arrest was demonstrably low. Few drug users came into contact with drug treatment programs, and of those who did relatively few stopped using drugs permanently.

Consequently, there was, starting in the mid-1960s, a rising demand for another form of control which would complement law and medicine. This was a demand for prevention, for programs which would somehow keep people from entering into the work of illicit drug use. And, since in the 1960s drug use was seen mainly as a problem of the young, the demand focused primarily on the need to create or update school-based programs.

The upward curve of this demand, and the remarkable speed with which it became the basis of a significant aspect of national drug control policy, may be charted by federal appropriations over the past five years for drug education and information programs. In fiscal year 1969, $2.7 million was appropriated, followed by $10.3 million in 1970, $24.1 million in 1971, $43.7 million in 1972, and $40.5 million in 1973.[2] These funds, disbursed through various federal agencies to establish programs at national, state and local levels, scarcely reflect the magnitude of the burgeoning drug prevention "industry," for an incalculable amount of money and effort for preventive programs has been generated by businesses, foundations, voluntary organizations, and other groups in the private sector. While it is probably true that most programs are based in the schools (a National Commission on Marihuana and Drug Abuse survey showed that, as of 1971, twenty-four states required drug education at secondary school level, and in the other states, many, if not most local school districts had developed programs on their own initiative[3]), it should be pointed out that many programs operate outside the schools in forums as diverse as the national television networks, local churches and civic groups, and so on.

It is clear, then, that the prevention of illicit drug use has become a major area of planned social action. It is also quite clear, as critics have begun to point out, that programs in this area, with few exceptions have not been evaluated.[4] As a result there are few empirical clues as to what drug prevention actually accomplishes; no one really knows whether preventive programs, by and large, achieve their goals. Moreover, the assumption that the concept of prevention is applicable to illicit drug use has largely gone unquestioned. So strong has this assumption been, constituting as it does the fundamental premise of the entire preventive enterprise, that only within the past year or two has it been asked: Is the prevention of illicit drug use a realistic, achievable goal? Or is it just wishful thinking?

The purpose of this paper is to examine the concept of prevention as it relates to the use of illegal drugs and to make explicit some of its limitations. In doing this we outline a model, or classificatory scheme, in which we can locate the various approaches to prevention.

THE CONCEPT OF PREVENTION

The concept of prevention was first developed in the field of public health and epidemiology. In the classic epidemiologic formulation, the spread of contagious disease among people depends on the interaction of an agent (the disease germ) with a host (the human organism) as mediated through a particular environment (physical and social). Given this formulation, which is greatly oversimplified here, prevention may, according to standard public health categories, occur at three levels. *Primary* prevention is aimed at keeping the agent from infecting potential hosts by, for example, immunizing the uninfected parts of the population or quarantining those already infected. *Secondary* prevention, through early case finding and diagnosis, seeks to limit the disease process among infected individuals in whom the process is not far advanced. *Tertiary* prevention aims at limiting disabilities among, and if possible rehabilitating, persons in whom the disease process has reached an advanced stage.[5]

As employed in the field of drugs, the concept of prevention has usually meant primary prevention and, to some extent, secondary prevention. In other words, the aim of preventive efforts has been to keep nonusers from becoming illicit drug users, and to help experimental or occasional users revert to nonuse, or at least to keep them from progressing to patterns of heavy use. Those who have reached the point of heavy involvement with drugs are typically seen as candidates for treatment; they are beyond the reach of preventive efforts. In this paper we shall adhere to the meaning of prevention commonly understood in the drug field; programs of treatment and rehabilitation for those already seriously involved with drugs will be considered herein to fall outside the area of prevention.

Since it is by now indisputably clear that most people are introduced to illicit drugs by intimate associates--usually friends, sometimes relatives--and not by the mythical pusher who loiters near schools, some persons in the field uphold a "contagion" or epidemiological model of drug use which views use as spread by direct contact. Under the auspices of this model, they propose classic public health measures, such as quarentining known users, or chemically immunizing nonusers.[6] It should be noted that these measures are usually recommended with respect to heroin addiction.

In our view, however, the contagion model has a significant shortcoming. Namely, unlike the case of an infectious disease, people contract the disease of drug use willingly; they *choose* to use drugs. There is, in short, an element of volition in drug use which the epidemiological model fails to encompass adequately.

Given this shortcoming, the model is of limited utility for discussing the wide range of efforts coming under the rubric of prevention. We therefore employ a different model, one which better fits the empirical facts. This is an economic model, first developed for somewhat different purposes by James V. Koch and Stanley E. Grupp, which treats factors of supply and demand as the organizing principles of analysis.[7]

Under the terms of this model, prevention in its broadest sense may be said to include, first, all efforts aimed at reducing the supply of drugs, and second, all efforts aimed at reducing the demand for drugs. Attempts to reduce the supply of drugs, especially through monitoring and interdicting the illegal drug traffic, fall, generally speaking, into the domain of law enforcement. Such activity may validly be called preventive to the degree that it curtails the drug supply and, in turn, restricts opportunities for drug use. However, since the drug field the term *prevention*, as commonly used, does not cover this kind of law enforcement activity, we shall eschew further consideration of the supply side of the equation and focus instead on the demand side, where virtually all preventive efforts, in the usual meaning of the term, may be located analytically.

In what follows we review the main approaches to prevention--that is, the strategies for reducing demand--and point out what appear to be the limitations of the various approaches. These are discussed under four headings: (1) coercion, or the threat of formal punitive sanctions; (2) persuasion, or education in the harmful consequences of drug use; (3) correction, or the eradication of the presumed causes of drug use; and (4) substitution, or the provision of alternatives to drug use.

COERCION

Throughout most of the twentieth century, the basic means American society has employed to reduce the demand for illicit drugs is the threat of punitive sanctions, as expressed through formal penalties codified in the law. This has been true at least since the passage of the Harrison Act in 1914, and the general trend, in response to the stubborn persistence of illegal drug use, has been to increase the severity of the penalties.[8] The major exception to this trend has been the reduction, over the past few years of penalties for marihuana possession.[9]

The theory behind the drug laws is that the threat of punishment will act as a deterrent, that through the instrument of the law people can be coerced into acting in their own best interests. But despite its preventive intent, the law, viewed as a strategy to reduce the demand for drugs, has clearly not proved effective. One could discourse at length on why this is so; but since the detection and arrest of drug possessors, like the case of drug traffickers, is typically considered a law enforcement matter and not a form of prevention, let us consider another kind of coercion, one which is often closely linked to programs generally recognized as preventive in nature. This is the application of extra-legal administrative sanctions by certain organizations, schools in particular, to individuals discovered to be in possession of illegal drugs.

Schools, from elementary to college level, have become the key site for preventive programs, and for two reasons. First, young people are seen as the primary "population at risk" in regard to drug use; and second, school settings permit an in-depth presentation and discussion of drug information. The substantive aspects of such programs are treated below. Here we note that school-based programs, especially at secondary and college levels, often include, in addition to the strictly educational aspects of the program, a warning to students that administrative sanctions may be applied to any of them discovered to be drug users. Typically, these sanctions involve the possibility of suspension or expulsion from school, although in some cases school policy may include notifying the police.[10] Whatever the arguments pro and con concerning the use of these sanctions, it is clear that such warnings are not always a hollow threat. In two noteworthy instances, midshipmen at the United States Naval Academy have been expelled for marihuana use.[11] A national survey of schools conducted for the National Commission on Marihuana and Drug Abuse showed that 50 percent of the 363 secondary schools sampled had suspended at least one student for involvement in a drug-related incident, and 21 percent had expelled at least one.[12]

Despite these facts, the use of administrative sanctions, considered purely as a means to reduce drug demand, has an important limitation. Most students, knowing school policy regarding illicit drugs, are not likely to use drugs in situations where there is a risk of detection by the school authorities. Given the high rate of campus drug use, it may be inferred that most drug-using students do not view detection as a significant possibility. It may also be, for obvious reasons, that many school administrators do not seriously attempt to identify drug users among their student populations. Thus it would seem that the most important function of the enactment of policies which include administrative sanctions is not to reduce the demand for drugs, but rather to placate parents, legal authorities and other interested parties outside the school, assuring them that the school administration is "doing something" about drugs.

No one, of course, pretends that administrative sanctions form the core of any prevention program; rather, they are ancillary to the main effort, which is to prevent drug use through nonpunitive means. From all indications, the most prevalent approach along these lines is education, or the attempt to persuade people by dint of information to abstain from drugs.

PERSUASION

The effort to reduce drug demand through persuasion rests on a key rationalist assumption "...that given valid information about the consequences of alternative courses of action, most people will not elect the course most likely to result in self-harm."[13] In a similar vein, Donald A. McCune, in his report on drug education to the National Commission on Marihuana and Drug Abuse, said:

> The general consensus among the public at large as well as many in the drug bureaucracy has been that primary prevention can best be achieved through effective education. The traditional rationale has been very simplistic: if an individual knows about the drugs and their harmful effects and if he understands fully the variety of social controls and punishments associated with the use of drugs, he will abstain from using such substances in order to avoid the consequences.[14]

In their review of school drug education curricula, Robert Boldt, Richard Reilly and Paul Haberman found that, "This concept expressed in different ways, is the pervasive theme of all the drug curricula reviewed."[15] Indeed, in their national survey of drug education practices of 342 elementary and 363 secondary schools, they discovered that, in the academic year 1972-73, the physical and psychological effects of drugs on the user was the single most emphasized topic in educational programs, with an identical proportion--85 percent--of the schools at both levels reporting this emphasis.[16] They found, furthermore, that the most frequently utilized educational technique, presumably used to convey this information, was audiovisual presentation (reported by 67 percent of the elementary schools and 70 percent of the secondary schools).[17]

The schools, of course, are only the most conspicuous example of this form of prevention. Persuasion has also been attempted at the national level through brief television messages, some developed with the support of the National Institute of Mental Health, which describe the dangers of various kinds of drug use.[18]

The sheer proliferation of drug education programs of one kind or another suggests that the rationalist assumption which underlies them--that is, that knowledge of the possible consequences of drug use will promote nonuse--has in effect become an article of faith, one which until recently has gone unquestioned.[19] It is becoming clear, however, that this approach to prevention has certain limitations.

First of all, attempts to persuade people not to use drugs, by force of information, fly in the face of a commonplace observation: even when they accept the information as valid, people often discount the risks and act against their own best interests. The use of cigarettes in this country is a classic case in point. This behavior might be termed the "not me" syndrome which expresses the individual's belief that harm will not befall him, only someone else. For example, a study of 155 narcotics addicts undergoing treatment in the California Rehabilitation Center showed that 81 percent of them claimed that when they first began to use narcotics they did not believe they would become addicted.[20]

Second, information may not be believed by its intended audience because its source is not seen as being credible. Several studies of students have indicated, for instance, that they often discredit drug information offered by law enforcement officers, clergymen, and school guidance counselors on the grounds that such persons are trying to promote "official" moral values.[21]

Third, drug information offered by an education program may not be in accordance with information individuals obtain from friends or from firsthand observations of drug use. In the event of such discordance, the discrepancy may be resolved by crediting only the latter kinds of information, since these generally indicate to the individual that the risks attached to drug use are not nearly so high as official sources would have him believe.[22] Howard S. Becker has pointed out that the drug subculture has its own informal ways of doing "research" on drug effects, and that the body of knowledge which results and is disseminated among users may be quite different from the information disseminated by official sources.[23] In fact, officially produced information often may be faulty. For example, the National Coordinating Council on Drug Education recently evaluated 220 films on drug use and rated 84 percent of them unacceptable. Council president Robert M. Earle said that, "The majority of these films are inaccurate, unscientific and psychologically unsound."[24]

The use of inaccurate information, especially that which exaggerates the dangers of drugs like marihuana, may produce, as a number of researchers have observed, an unfortunate "boomerang" effect. That is, if a program's audience disbelieves information on drugs which in their experience are not terribly dangerous, they may also discredit information on drugs which in their experience are not terribly dangerous, they may also discredit information on drugs whose dangers are more certain, and thus be induced to try them.[25]

One might assume that the latter problem can be solved by having programs issue only accurate information. However, as the National Commission on Marihuana and Drug Abuse has noted, drug education programs face a special dilemma:

> Prevention programs may proclaim goals which stress the prevention of high-risk drug use, or of drug dependence, or use of particular drugs, but in practice they must try to curtail all illicit drug use. Programs which expressly emphasize the harm of certain use patterns imply that other patterns are relatively harmless and thus tacitly condone them. Since this is unacceptable, education-information programs usually take the opposite tack; they suggest that all use patterns are equally harmful, because all are likely to evolve into undesirable behavior.[26]

The fourth limitation to the persuasion approach is that educational programs, even when they take care to deliver accurate information, may actually stimulate drug use rather than deter it. This possibility is suggested by the research of Richard B. Stuart, to our knowledge the only research designed to assess the effects of a drug education program on the drug use behavior of its audience.[27] Space limitations prohibit details, but the research was done in experimental form, with 935 students in two suburban junior high schools being randomly assigned to experimental drug education or to control groups. The experimental group was given a ten-session fact-oriented drug curriculum, taught over a ten-week period. Pre- and post-measures were made of the use and sale of various drugs, as well as of drug related knowledge and attitudes. For some students, follow-up data were obtained four months after the program (all data were collected in the 1971-72 academic year). The key findings, for this discussion, were that the experimental group, compared with the controls, showed a sizable increase in the use of alcohol, marihuana and LSD, and also became more involved in the selling of the latter two drugs.

Given these findings, a difficult problem arises: If programs which present distorted information induce a certain amount of illicit drug use through a "boomerang" effect, and if programs which strive for honesty also induce a certain amount of use (perhaps by a combination of increasing knowledge and reducing worry about possible harm, as Dr. Stuart's research suggests), is there a viable role for drug education programs? Are efforts based on persuasion a tenable means of reducing the demand for illicit drugs? The definitive answers to these questions are not known, but at the moment the evidence is not promising. It is not surprising, then, that in early 1973 both the National Commission on Marihuana and Drug Abuse and the Federal Special Action Office for Drug Abuse Prevention called for a moratorium on production and dissemination of new drug education materials.[28] It should be noted that neither agency recommended a complete halt to drug education efforts, but a moratorium would allow time for evaluation and critical appraisal of goals, methods and results of programs currently in operation.

CORRECTION

An approach to prevention which has recently gained currency is correction, or the attempt to reduce drug demand indirectly by dealing with the presumed causes of illicit drug use. A vast body of research on the etiological factors involved in drug taking indicates that the causes are multiplex, ranging from the individual level (personality attributes), to the interactional level (differential access to and involvement in drug-using groups), to the macrosocial level (for example, the evolutionary trend in our society toward acceptance of mildly hedonistic forms of recreation).

Obviously, some causal factors are beyond the reach of preventive efforts. For instance, a number of recent studies show that youthful drug users come disproportionately from families in which the parents use alcohol, tobacco, and prescription drugs.[29] These youngsters, in effect, socially inherit a predisposing orientation to substance use which facilitates their decision to try illegal drugs when introduced to them by peers. The problem, of course, is that by the time a youngster is exposed to a prevention program, the substance use patterns of his or her parents have probably had their effect; there is no way to go back in time and try to change these patterns.

Because of such difficulties, preventive efforts which address causal factors tend to focus on the attributes of the individual, in particular his or her value system. The key approach along these lines, as practiced in many school-based programs, is what has been variously called "affective education," "humanistic education," or "value clarification." The thrust of this approach is to help youngsters, through a number of techniques such as role playing, to form their values consciously, so that in time they will become autonomous individuals, capable of making rational decisions based on those values. A typical statement of this approach is one made by Henry A. Kane and Doris Pearsal:

> Students should be helped to develop a sense of inherent self-worth and uniqueness which will lead to the choice of positive and viable alternatives in life rather than self-destructive ones ...Assistance for each student in the clarification of individual values and value systems for himself and in relation to his individual choice of life style should pervade all areas of discussion. Students should be helped to develop a mutuality of respect for others who hold different values from their own, while at the same time developing a confidence and trust in one's own values and a willingness to live one's life in accordance therewith.[30]

The assumption apparently underlying this approach is that once an individual's values are "clarified," he or she will refrain from drug use. But given the current absence of evaluation data, that remains, empirically, an open question.

Theoretically, the approach has an important limitation; that is, the overriding values it recommends--as distinct from whatever specific values students may form--may foster rather than inhibit drug use. The above quotation, taken on face value, advocates self-construction of individual values rather than unquestioning acceptance of received values; individual choice of life style rather than unthinking conformity to dominant life styles; and tolerance of differences of others. These are precisely the kinds of values which many studies have found illicit drug users to hold, and which distinguish them from nonusers to a large degree.[31] These studies have shown that drug users, as compared with nonusers, tend to be more self-exploratory, more open to experimentation with different life styles, and more tolerant of unconventional behavior. If the affective education or value clarification approach truly promotes these values, then in the long run, whatever its other potential merits, this approach may do little to reduce the demand for drugs.

SUBSTITUTION

A final approach to reducing drug demand is substitution, or the provision of alternatives to drug use, especially natural or nondrug "turn-ons." This approach is often recommended in prevention literature, but it is undoubtedly less widely practiced than are the approaches discussed above, at least in the sense of its forming the basis of actual programs.

The approach rests on the premise that there is something in the drug experience which users seek, and that this can be gained through nondrug means. For example, the National Commission on Marihuana and Drug Abuse has recommended that "...drug use prevention strategy, rather than concentrating resources and efforts in persuading or 'educating' people not to use drugs, emphasize alternative means of obtaining what users seek from drugs: means that are better for the user and better for society."[32]

The question of course, is: What do users seek through drugs? Some theorists see drug use as resulting from a lack of meaningful experiences, or a lack of relevant "connectedness" to others, a kind of socio-psychological isolation, as it were. They recommend that opportunities be made available for people to become involved in pursuits--community work, the arts, craft skills, and new recreational programs--which will provide personal fulfillment and a sense of meaningful involvement with others.[33]

Others believe that drug users basically seek altered states of consciousness. Drug authority Andrew Weil holds that the desire occasionally to experience such states is an innate drive.[34] Accordingly, somewhat more esoteric alternatives are recommended which will induce altered states of consciousness, including yoga and meditation.[35]

The limitation to this approach is that, in principle, none of these alternatives is necessarily mutually exclusive with drug use. It may be perfectly possible to become intensely involved in community work, or in the arts, or to practice yoga--and still use drugs. Indeed, several studies of student drug users have shown that, compared with nonusers, they are more involved in political activities and in artistic pursuits.[36]

More important, perhaps, is the real possibility that none of the alternatives provides what users seek from drugs. Marihuana users, for example, typically report that the drug is a sensory intensifier, that it greatly increases their enjoyment of music, food and sex.[37] If this is one of the significant reinforcing aspects of the marihuana experience, it is difficult to see what can substitute for it.

CONCLUSION

Using a simple supply-demand model, we have asserted that most efforts at prevention, as the term is ordinarily understood, are strategies intended to reduce the demand for drugs. We have reviewed four major strategies or approaches: coercion, persuasion, correction, and substitution. And we have pointed out what appear to be the limitations of each.

The picture, frankly, is not hopeful. If the goal of prevention is to curtail all illicit drug use, then it is fair to say that, on the basis of currently available evidence, none of the approaches has proved effective.

Perhaps the time has come, as several observers have suggested, to admit that the prevention of all illegal drug use is not an achievable goal.[38] Perhaps the time has come to adjust our goals and focus our preventive efforts primarily on high-risk patterns of use--on those patterns, that is, where drug involvement demonstrably and significantly increases the chances of self-harm. (This is not to suggest, incidentally that prevention programs should not continue to reinforce those who have already decided to abstain from drugs. This is an important group, one which should not be neglected, and their decision should be given sustained support.)

Whether any of us likes it or not, reality intrudes. The reality is that some forms of drug use, particularly patterns of moderate recreational use, are firmly institutionalized in certain sectors of society. While the most troubling aspect of the drug problem--the high-risk patterns of use--becomes ever more visible and unquestionably warrants our deepest concern, we should not overlook the fact that there is an underlayer of episodic, moderate or low-risk drug use which is resistant to change. To try, then, to prevent all illicit drug use merely diffuses our energies, with the probable result that we will accomplish less than we otherwise could.

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MODULE III

MODULE III: CURRENT PREVENTION STRATEGIES

TIME: 3 HOURS 20 MINUTES

GOALS

- Familiarize participants with existing drug abuse prevention programs and strategies, as categorized by NIDA's prevention continuum
- Acquaint participants with a variety of prevention program choices.

OBJECTIVES:

At the end of this module, participants will be able to:

- Identify at least one current prevention strategy for each component of NIDA's prevention continuum
- Identify the major target areas for drug abuse prevention programs
- List at least five existing prevention programs and describe their general approaches
- List at least three prevention approaches that are consistent with their individual prevention philosophy.

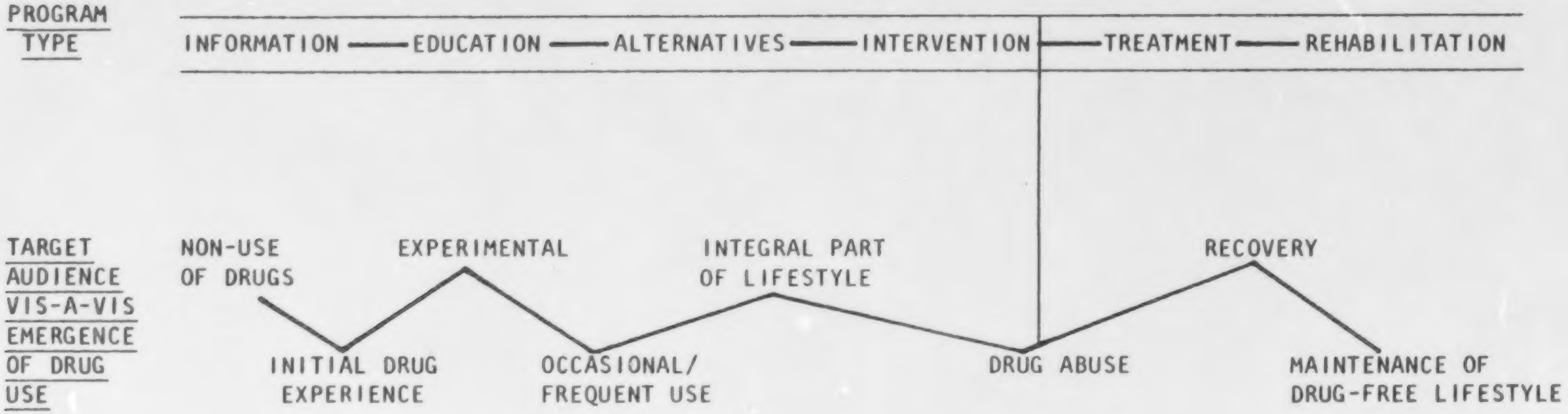
MATERIALS:

- Newsprint
- Magic Markers
- Pencils
- Diagrams
    - NIDA continuum
    - Prevention programs
    - Correlate research examples
    - CMA model
- Worksheets
    - Matrix

MODULE III — OVERVIEW

EXERCISE	TIME	METHODOLOGY
1. PREVENTION MODELS--IMPLICATIONS FOR PROGRAMMING	45 MINUTES	LECTURE/DISCUSSION
2. TARGET GROUPS	10 MINUTES	LECTURE/DISCUSSION
3. CORRELATES OF DRUG ABUSE	20 MINUTES	LECTURE
4. DEVELOPMENTAL FACTORS	15 MINUTES	LECTURE
5. SUMMARY	5 MINUTES	DISCUSSION
6. THE MULTICULTURAL OR COMMUNITY DEVELOPMENT MODEL	20 MINUTES	LECTURE/DISCUSSION
7. TYING IT ALL TOGETHER	30 MINUTES	SMALL-GROUP EXERCISE
8. SUMMARY	5 MINUTES	DISCUSSION

DRUG ABUSE PROGRAM CONTINUUM


PROGRAM TYPE
INFORMATION — EDUCATION — ALTERNATIVES — INTERVENTION — TREATMENT — REHABILITATION
TARGET AUDIENCE VIS-A-VIS EMERGENCE OF DRUG USE
NON-USE OF DRUGS
INITIAL DRUG EXPERIENCE
EXPERIMENTAL
OCCASIONAL/ FREQUENT USE
INTEGRAL PART OF LIFESTYLE
DRUG ABUSE
RECOVERY
MAINTENANCE OF DRUG-FREE LIFESTYLE

PREVENTION PROGRAMS

INFORMATION

- Accurate information
  - -Legal and illegal drugs and their effects
- Target specific for maximum results

ALTERNATIVES

- Constructive activities that meet developmental needs of youth
- Ownership and self-investment
- Constructive peer pressure

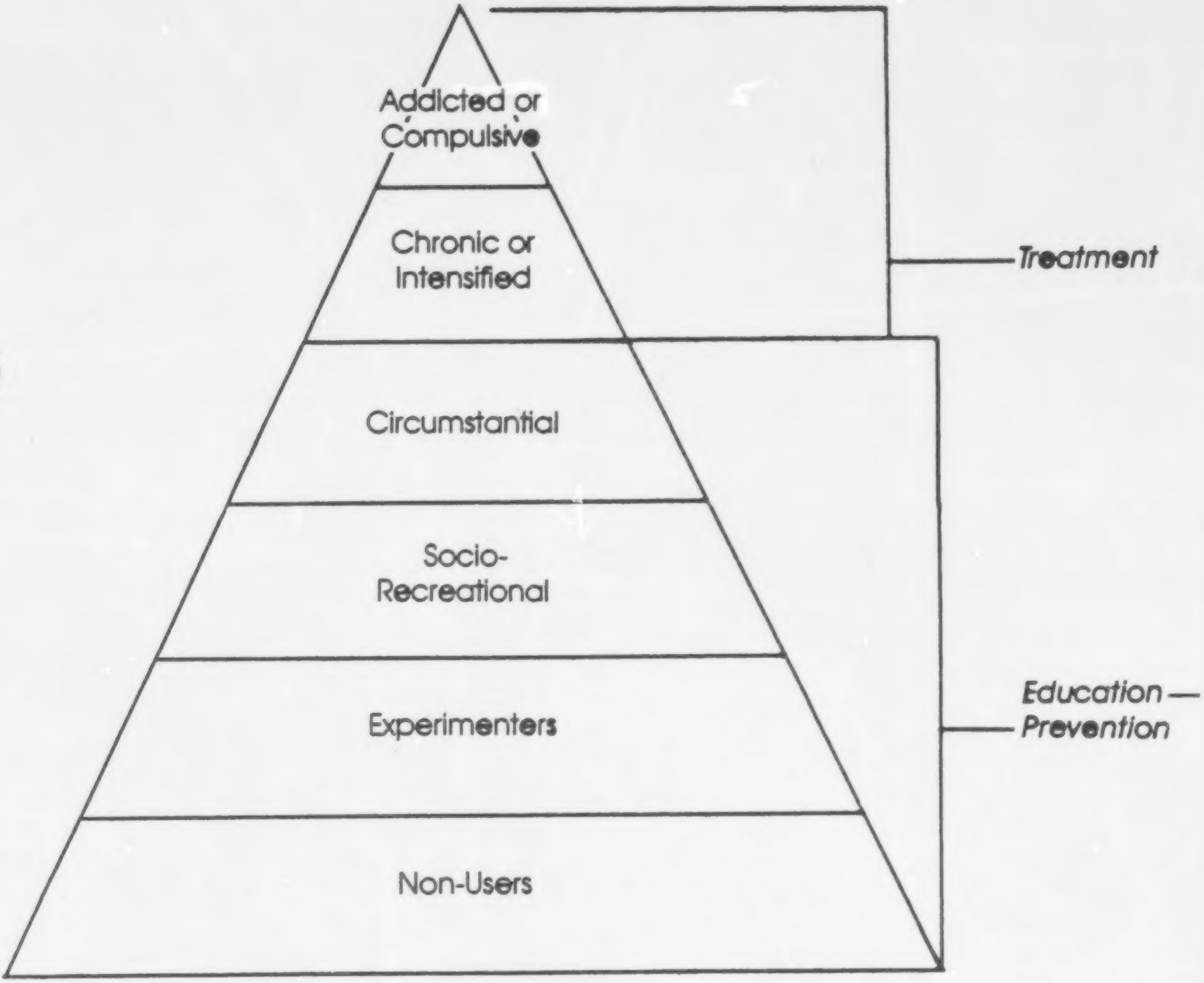
EDUCATION

- Process to help individuals develop skills to help themselves
  - -Decisionmaking skills
  - -Values awareness
  - -Communications
  - -Self-understanding
  - -Parent-family involvement
  - -Curricula
  - -Counseling

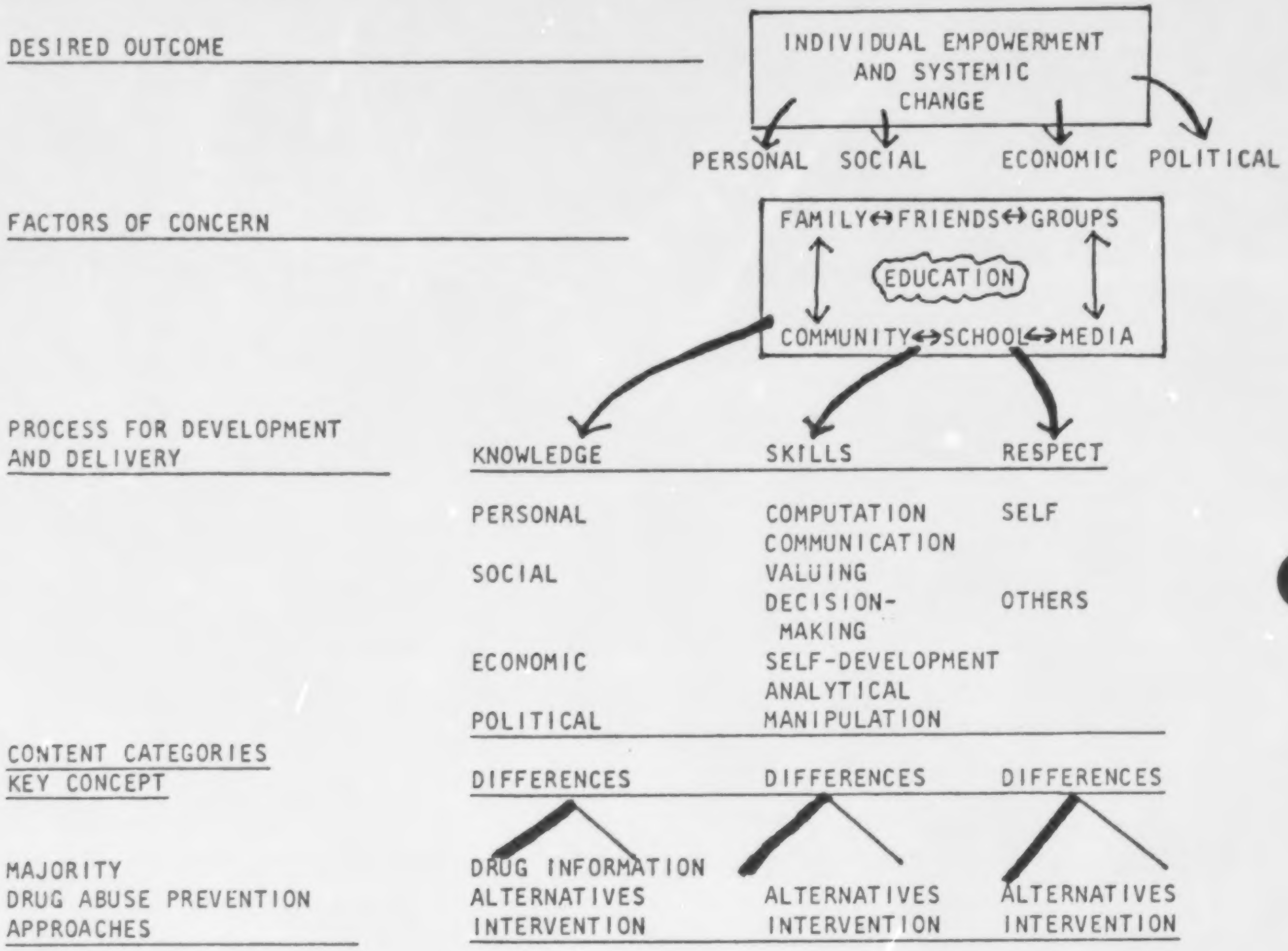
INTERVENTION

- Specific assistance and support for youth usually at high risk
  - -Counseling
  - -Hot lines
  - -Cross-age tutoring
  - -New peer group creation

MODULE III: CURRENT PREVENTION STRATEGIES--3 FIGURE


Addicted or Compulsive
Chronic or Intensified
Circumstantial
Socio-Recreational
Experimenters
Non-Users
Treatment
Education — Prevention

MULTICULTRUAL DRUG ABUSE PREVENTION--AN IMPLEMENTATION DESIGN



DESIRED OUTCOME

INDIVIDUAL EMPOWERMENT
AND SYSTEMIC
CHANGE

PERSONAL SOCIAL ECONOMIC POLITICAL

FACTORS OF CONCERN

FAMILY↔FRIENDS↔GROUPS
EDUCATION
COMMUNITY↔SCHOOL↔MEDIA

PROCESS FOR DEVELOPMENT AND DELIVERY

KNOWLEDGE	SKILLS	RESPECT
PERSONAL	COMPUTATION COMMUNICATION	SELF
SOCIAL	VALUING DECISION-MAKING	OTHERS
ECONOMIC	SELF-DEVELOPMENT ANALYTICAL	
POLITICAL	MANIPULATION	

CONTENT CATEGORIES
KEY CONCEPT

DIFFERENCES	DIFFERENCES	DIFFERENCES

MAJORITY
DRUG ABUSE PREVENTION
APPROACHES

DRUG INFORMATION ALTERNATIVES INTERVENTION	ALTERNATIVES INTERVENTION	ALTERNATIVES INTERVENTION

MODULE III: CURRENT PREVENTION STRATEGIES--1 **WORKSHEET**

DRUG ABUSE PREVENTION MATRIX

MODALITY

FOCUS	INFORMATION	EDUCATION	ALTERNATIVES	INTERVENTION
INDIVIDUAL				
FAMILY				
PEERS				
SCHOOLS				
OTHER SOCIAL INSTITUTIONS				

DRUG ABUSE CORRELATES - Selected Examples

Research has investigated the relationship of drug abuse to other adolescent behaviors, attitudes, characteristics, and environments. It is important to remember that these relationships are correlative (i.e. so related that each implies or complements the other) rather than causal. To reiterate, no empirical research exists which definitely establishes the causes of drug abuse; much information has been gathered around the attitudes and behaviors which are associated with the destructive use of drugs, as well as other self-destructive use of drugs, as well as other self-destructive and anti-social behaviors.

In an early (October, 1976) reveiw of correlate research, NIDA's Prevention Branch outlined six categories of correlate research:

1. Individual correlates
    a. Personality (e.g., attitudes towards self, values, social, and political attitudes, locus of control, achievement orientation, peer or adult orientation)
    b. Behavioral (e.g., school or vocational performance, interpersonal or group involvement, recreational, and avocational activities)
    c. Demographic (e.g., age, religion, ethnicity, geography, and socio-economic status)
2. Family correlates
    a. Intra-family interactions (e.g., child raising practices, rituals and habits, power and status dynamics)
    b. Family structure/status (e.g., size, birth order, and socio-economic status)
    c. Characteristics of the family group members (e.g., parent and sibling use patterns)
3. Peer group correlates
    a. Peer group norms/interest (e.g., drug use patterns, values, participation in organized activities)
    b. Peer group structure/status (e.g., group size, stability of the group, and intra-group dynamics)
4. School-related correlates
    a. School structure/policy (e.g., policy-making procedures, punishment and grading practices, and general orientation towards education)
    b. Classroom climate (e.g., content of curriculum and characteristics of teacher)

   c. Drug-specific policies procedures (e.g., drug education programs, rules, and penalties regarding drug use)

5. Community correlates

   a. Community demographics (e.g., ethnicity, urban/suburban/rural, socioeconomic status, and stability)

   b. Community service policies (e.g., recreational, cultural, human services, and law enforcement)

6. Societal correlates

   a. Societal structure/policy (e.g., economics, legislative and enforcement policies, and mass media influences)

   b. Cultural norms, values, myths.[1]

Research has established both positive and negative correlations of drug abuse and attitudes and behaviors. Some examples are:

1. Drug abuse has been positively correlated with:

   a. Knowledge of drugs (Fejer, D. & Smart, 1973)

   b. Attitudes towards use (Fejer, D. & Smart, 1973)

   c. Iintentions to use (Tzeng and Skafidas, 1975)

   d. Use of other drugs (Annis, H.M., 1971)

   e. Impulsivity (Cisin, I. & Cahalan, 1978)

   f. Alienation (Block, J.R., 1975)

   g. Excessive personal stress (Duncan, 1977)

   h. Sensation seeking (Segal, B., 1975)

   i. Boredom (McLeod & Grizzle, 1972)

   j. Assertiveness (Horan, J., D'Amico & Williams, J., 1975)

   k. Anti-social tendencies (Galli, N. & Stone, 1975)

   l. Rejection (Braucht et al., 1973)

   m. Reliance on peer group for drug information (Guinn, K., 1975)

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[1] NIDA Prevention Branch, "Correlate Research Review, "Division of Resource Development, National Institute on Drug Abuse, Rockville, Md. 20857, October 1976.

Reference Sheet III-1 Continued

n. Skepticism about school drug education programs (Fejer and Smart, 1973)

o. Septicism about media prevention efforts (Hughes, Sanders, & Schaps, 1977)

p. Peer approval of deviant behavior (Jessor, R., 1971)

q. Peer pro-drug attitudes and behaviors (Bowker, L.H., 1974)

r. Parental use of drugs or alcohol (Annis, H., 1971)

s. Parental medication use (Blum, R.H., 1972)

t. Lack of parental concern (Baer & Corrado, 1974)

u. Parental permissiveness (Baer & Corrado, 1974)

v. Childhood stress and trauma (Pittel, S. et al., 1971)

w. Absence of a parent (Carney, Timmes, & Stevenson, 1972)

x. Family instability & disorganization (Braucht et al., 1973)

y. Quality of the relationship in the family (Bracht et al., 1973)

z. Over- and under-dominated by parents (Bracht et al., 1973)

aa. Harsh physical punishment (Baer & Corrado, 1974)

bb. Rejection by parents (Braucht et al., 1973)

2. Drug abuse has negatively correlated with:

a. Self-esteem (Smith and Fogg, 1975)

b. Liking of school (McLeod & Grizzle, 1972)

c. Grades and achievement (Guinn, 1975 and Carnat, 1972)

d. Decision making (Segal, 1975)

e. Self-reliance (Segal, 1975)

f. Feelings of belonging (Galli & Stone, 1975)

g. Religious beliefs (Smith & Fogg, 1975)

h. Optimism about the future (Mellinger, Sommers, & Mannheim, 1975)

i. Humanistic environment in the school (McLeod & Grizzle, 1972)

j. Alternate education programs for drop-outs and underachievers (Korotkin, 1975)

k. Involvement of community institutions in youth problems and programs (Channel 1, Exodus)

l. Clear, consistent child rearing practices (Jessor and Jessor, 1972)

m. Parent religiosity (Jessor & Jessor, 1972)

n. Parental intolerance of deviance (Prendergast, 1974)

o. Presence of controls and regulations in home (Hunt, 1975)

p. Extended family (Blum, R.H., 1972)[2]

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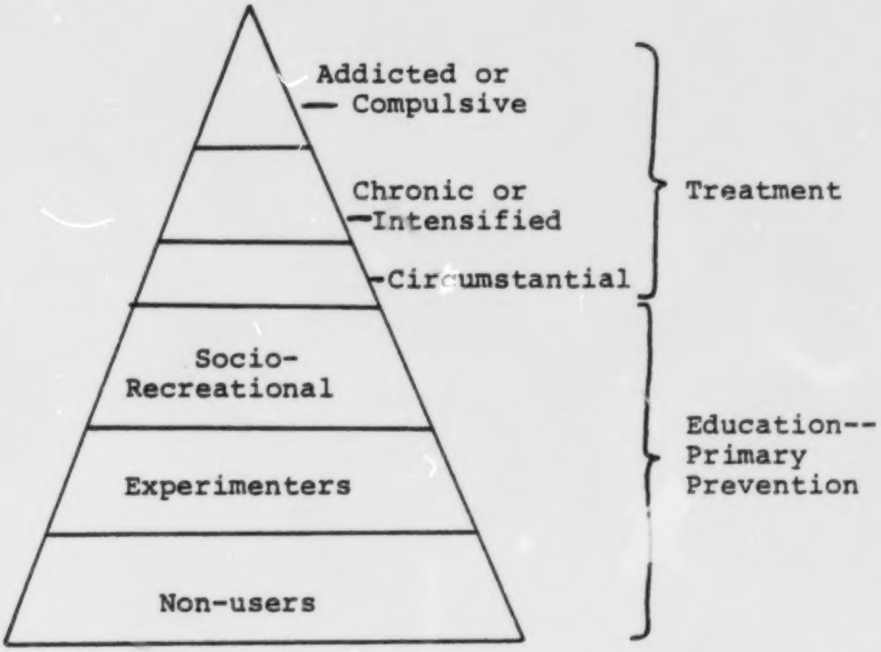
[2] From the NIDA Prevention Briefing Book, Prevention Branch, Division of Resource Development, National Institute on Drug Abuse, Rockville, Md. 20857, 1979.

TARGET POPULATIONS FOR PREVENTION AND TREATMENT

Reprinted from Community-Based Prevention Specialist, National Drug Abuse Center for Training and Resource Development, Arlington, Va., October, 1977.

TARGET POPULATIONS FOR PRIMARY PREVENTION AND TREATMENT


Addicted or Compulsive
Chronic or Intensified
Circumstantial
Socio-Recreational
Experimenters
Non-users
Treatment
Education--Primary Prevention

Non-users: Self-explanatory; persons who have never tried an illicit drug.

Experimenters: Drugs do not play a regular role in their life. Use is episodic and reflects a desire to see what the drug is like or to test the effect on activities ordinarily experienced drug free. The drug is usually tried once or twice, but for various reasons, use is discontinued.

Socio-Recreations: This behavior occurs in social settings among friends or acquaintances. It reflects a desire to share an experience that is defined as both acceptable and pleasurable. The pattern of drug use is occasional and situationally controlled. The drugs are associated with activities in which this type of user would take part, whether or not drugs were present.

Circumstantial: This behavior is generally motivated by the user's perceived need or desire to achieve a new and anticipated effect in order to cope with a specific problem situation or a vocational condition (e.g., a long-distance truck driver).

Chronic or Intensified: These subgroups are self-medicators. Both groups often use drugs as a type of self-therapy, among other reasons. Time is dedicated to seeking out drugs or making connections to obtain them. The user cannot enjoy or cope with situations without drugs. The self-medicator typically uses tranquilizers or stimulants that are distributed legally. This type of use may become a habitual way of responding to boredom, loneliness, frustration, and stress.

Addicted or Compulsive: This category is characterized by a high degree of psychological dependence and perhaps physical dependence. Drugs dominate the individual's existence; this preoccupation with drug taking precludes other social functioning. The process of securing and using drugs interferes with essential activities.

MULTICULTURAL APPROACHES IN ALCOHOL, DRUG ABUSE AND MENTAL HEALTH PREVENTION PROGRAMS

Paper prepared by Carolyn R. Payton, Director, Center for Multicultural Awareness, for the First Annual Alcohol, Drug Abuse, and Mental Health Administration Conference on Prevention, Silver Spring, Md., September 13, 1979.

EXECUTIVE SUMMARY

This paper summarizes some of the recent research and evaluation of drug and other substance abuse programs and directs attention to the work of NIDA and ADAMHA, with special reference to the possible impact of this work on efforts to alleviate drug abuse problems, particularly among ethnics of color. It is contended and supported that the bulk of research fails to include those socio-economic, those street factors, that make the solution more difficult, or at least different, for minorities. The admitted paucity of data on minorities in this research is attributed, in most cases, to sampling problems but the author contends that these are much less important than the street-wisdom and authority-avoidance that can very effectively skew the data.

Commonalities and differences are explored between majority and minority drug abusers, emphasizing differential access to vital information for the minorities. For example, the NIDA design classifies prevention programs into Information, Education, Alternatives and Intervention. The author submits that such a model addresses the majority and not the minority, pointing out that delayed education obstructs the flow of information, that low high school attendance allows the most vulnerable group to miss a most potent source of information, the classroom, and that housing and income-poverty are insufficiently considered, thus obstructing the flow of assistance to be found through Alternatives and Intervention. Alienated groups will not be reached through conventional procedures based on samples derived primarily from majority groups.

Ethnic concerns about drug abuse prevention strategies are inadequately addressed at the national level and the focus on impact measures, evaluation procedures and requirements can be threatening to the uninitiated. Sophisticated evaluation techniques, however commendable regarding statistical significance and levels of confidence, are meaningless to the street worker who must spend time worrying about loss of funding, through lack of chi square, and not enough time addressing the goals and objectives in human terms. The taxpayer is certainly entitled to know how funds are being spent and how effective programs are; policy makers are, and should be, accountable. However, the methods by which this accounting is done need not fall into experimental designs and control groups more appropriate to rats than to human beings. The senior level managers of grants should be satisfied with "good evidence" that the programs are doing what they originally claimed could happen as a result of funding. There are many ways to accomplish this: informal, non-structured interviews, minutes of meetings, attendance at activities, body-counts if you will. Evaluations should not be viewed as obstacles, but rather as consultative elements of long-range assistance.

Finally, an effective multi-cultural approach to drug abuse and other substance abuse, including mental illness prevention, should incorporate recommendations made to the President's Commission by the Special Populations Subpanels--and without delay. Enough esoteric research has been done to request a moratorium on all further analytical studies until we know the results of the work and effort now in place.

INTRODUCTION

Ethnics of color who may have read position statements of the current administration might be encouraged, take heart, from the recognition given to the specific concerns of minorities in the fields of mental health, alcohol and drug abuse prevention programs. For example, the 1978 Policy Review on Drug Use Patterns, Consequences and the Federal Response devotes almost two pages to the topic of ethnic (sic) Minorities. The 1979 Federal Strategy for Drug Abuse and Drug Traffic Prevention cites as one of the key elements of prevention, planning and developing materials for ethnic minorities. Dr. Helen Nowlis, in a statement prepared for the Select Committee on Narcotics Abuse and Control Hearings of May 1979, describes activities of the Office of Education which support programs tailored to the ethnic and demographic needs of communities. President Carter's Message to the Congress includes this statement: "Among some minority groups the incidence of addiction and the harm it inflicts are disproportionate." The Report to the President from the President's Commission on Mental Health also reflects attention paid to America's ethnic and racial populations and the need to take into account the different cultural traditions.

It would appear, then, that the Federal Government has sensed the suffering of minorities caused by substance abuse and other elements within the society and does, indeed, support action to reduce the resulting harm. However, trying to document the actual extent of substance abuse or mental illness among minorities seems impossible.

Drug Use Patterns, Consequences and the Federal Response: A Policy Review, makes the following statement on the subject:

> "Assessing the drug abuse problems in ethnic minority communities is a complex and difficult task, in part because of the lack of research information and data on the nature of the drug problems of such groups. /1/

One wonders why this should continue to be true, given the resources of the Federal Government. There are those who regard with some suspicion the concluding sentence of the above quoted statement - "This has hampered efforts to make the drug programs and resources of the Federal Government available, accessible, sensitive and relevant to minority community concerns." Many minorities would assert that this relationship - lack of data and lack of resources - is deliberate. As long as the incidence and prevalance of maladaptive behavior is unknown, substantial misconceptions can develop and resources can be misallocated. The Institute for Social Research at the University of Michigan, under a research grant from the National Institute

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/1/ Drug Use Patterns, Consequences and The Federal Response: A Policy Review. Office of Drug Abuse Policy, Executive Office of the President, March 1978, p. 35.

on Drug Abuse, has published a very extensive report dealing with drug use, attitudes about drug use, and the perceived availability of drugs among high school seniors in 1977. The authors cite as rationale for their survey the following:

-- Accurate assessment of size and contours of the problem of illicit drug use among young Americans is important for public debate and policymaking.

-- Reliable trend data permits assessment of the impact of major historical and policy induced events.

-- Reliable trend data will help in early detection and localization of emerging problems. /2/

These are quite laudable objectives and are equally desirable for minority youth. However, the data presented are analyzed by sex, college plans, region of the country, and population density or urbanicity, but not ethnicity. A rather curious omission.

No doubt the explanation for the omission is the usual - "The sample used for most surveys do not provide enough cases for a reliable assessment of the status of minority groups."

The 1977 National Survey on Drug Abuse /3/ does break out some of its data in terms of whites and nonwhites. But such displays are little better than useless, as drug usage varies within groups and between groups and ranking of drugs in terms of perceived harm differs by groups. The aggregation of all ethnic groups into one statistic can be misleading because the statistics tend to obscure the very real differences among ethnic groups. Such figures can lead to false inferences and counterproductive policies and actions.

It is acknowledged that since minority populations are relatively small, compared to the majority, and are distributed geographically in diverse patterns, a larger sample than is commonly used is necessary to ensure adequate coverage of the minority populations. Although, increasingly, better and more timely statistical information is provided for blacks and Hispanic Americans, the largest minority groups, it is rare to find a statistical report that provides separate tabulations on such groups as American Indians, Chinese Americans, Japanese Americans, Mexican Americans, Cuban Americans and Puerto Ricans.

/2/ Drug Use Among American High School Students: 1975-1977, National Institute on Drug Abuse, U.S. Department of Health, Education & Welfare, Publication No. (ADM) 78-619, p.

/3/ National Survey on Drug Abuse: 1977, National Institute on Drug Abuse, U.S. Department of Health, Education & Welfare, Publication No. (ADM) 78-618, 1977.

Most of our knowledge of drug usage among minorities is based on data from institutions and social agencies--hospitals, coroner's offices, police agencies, treatment programs--and represent counts of various critical events related to drug use. The Client Oriented Data Acquisition Process (CODAP) is illustrative of this tendency to provide statistical information on clients admitted to treatment in federally-funded clinics. The Drug Abuse Warning Network (DAWN) gathers drug abuse data from a sample of hospital emergency rooms, offices of medical examiners and County Coroners, and crisis intervention centers and also typifies sources used for drug information among minorities. Rarely, if ever, is assessment found of drug use on those segments of the minority population who do not come to the attention of these agencies. It is safe to assume that a significant proportion of this group have little or no contact with such agencies as listed.

The distortions that may result from employing such a limited sample is readily apparent. One hears, for ecample, that heroin-related death and emergency room visits (the drug most frequently linked in the public's mind with Blacks) is at an all time low. The conclusion is reached that the heroin problem is decreasing. Minorities interpret this to mean that funds for addressing this problem will also be decreasing. Minorities also recognize that heroin addicts may have learned to avoid those institutions which have provided the statistics originally. Thus the "reduction" may be but an artifact of street wisdom.

Information on the extent of mental disorders by race is also shaky. Kramer, Rosen and Willis /4/ point out the inadequacy of statistics on this phenomenon. They too conclude that such data are needed to plan programs to eliminate the attitudes, practices, and conditions of life that affect so adversely the physical and mental health and social well-being of minorities and to allow evaluation of efforts to accomplish this goal.

This entire issue of factual data on minorities and mental disorders, abuse of drugs and alcohol, has been captured succinctly by Dr. Sue Stanley in a paper presented at the National Conference on Minority Group Alcohol, Drug Abuse and Mental Health Issues. She states:

> First, in the stage of the status of ethnic minorities we need an increase in the quantity and quality of research studies. Because of methodological, conceptual, and practical problems in ethnic research we are still at the elementary steps in having systematic and accurate information on various ethnic groups.... We lack basic and essential information. For example, we still do not know how many Asians are in the U.S. Estimates vary from official sources to community leaders. The same situation exists for Mexican Americans. There is

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/4/M. Kramer, B. Rosen, and E. M. Willis, "Definitions and Distributions of Mental Disorders in a Racist Society," Racism and Mental Health, ed. C. Willie, Bernard Kramer, and Bertram Brown (Pittsburgh: University of Pittsburgh Press), 1973.

still a great deal of controversy over the rate and extent of mental disorders, drug abuse, and alcoholism among ethnic group individuals./5/

Even if statistics describing drug use patterns and consequences among minorities are missing or are biased and inaccurate, these groups are as concerned with preventing drug abuse as the majority group. Primary prevention strategies, in general, have had a rocky history and this is no less true of prevention activities generated by or for members of minority communities. The May issue of the Monitor, the house organ of the American Psychological Association, in several articles reviews some of the criticism provoked by the advocation of prevention. Although the focus is primary prevention of mental disorders, the same criticism applies to drug and alcohol abuse prevention. Key points made were:

- The time is not right for prevention as more research is needed on causal factors.
- Efforts to intervene with healthy people to reduce the incidence of disorders in Utopian nonsense.
- Is there a best way to deliver preventive services?
- Prevention is bad for the business of psychotherapists (and drug and alcohol treatment professionals).
- Where is the evidence that prevention makes a difference?

However, a most convincing argument for supporting primary prevention is also made by George Albee in an editorial printed in the same issue of the Monitor. Dr. Albee states:

> In view of the lessons of history and present reality, it is paradoxical that the bulk of current health care is directed at treatment rather than prevention. There has been dramatic improvement in the overall health of a majority of Americans during this century, but this improvement has been the result of successful prevention through better nutrition, pest and pollution control, vaccination and sanitation..../6/

The impetus that primary prevention is currently experiencing must be continued and advanced on both humanitarian and pragmatic grounds. Primary prevention models draw attention to the social context in which aberrant behaviors (mental disorders, drug and alcohol abuse) arise. Treatment allows the causal factors of such behavior to continue unmodified, to wreak damage over and over again.

/5/ Sue Stanley, "Ethnic Minority Research: Trends and Directions," paper presented at the National Conference on Minority Group Alcohol, Drug Abuse and Mental Health Issues, Denver, Col., May 1978, p. 7.

/6/ George Albee, "Preventing Prevention," APA Monitor, May 1979.

COMMONALITIES AND DIFFERENCES

The national policy of primary prevention of drug abuse postulated by NIDA stresses the relationship of drug abuse by young people to personal and social development. Further, the NIDA design neatly categorizes possible prevention programs as: Information - Education - Alternatives and Intervention. Minority groups have no difficulty with this conceptualization and therein lies the commonalities between the dominant and minority societies. Self actualization is certainly highly prized and valued by Blacks, Native Americans, Asians, Hispanics. Minorities would also agree that the various categories identified by NIDA can and do provide avenues for the development of self-esteem; the raising of levels of aspiration.

Nevertheless, minorities know that the prevention model defined by NIDA does not embrace elements significant to the groups. An inference which can be made from an analysis of the model is that if steps are taken to promote personal and social growth, barriers to reaching full individual potential will have been removed. This is simply not the case for minorities. All of the affective education, any amount of drug information (scary or not scary), values clarification or decisionmaking-problemsolving skills will not remove one stone from the wall of the race-related prison enclosing minorities in this country. There cannot be an effective primary prevention drug abuse, alcohol abuse, or mental disorder program for minorities which fails to deal with the reality of growing up in these United States. For policy-makers to continue to believe and behave as though prejudice and racial oppression are insignificantly related to the drug problems of minorities is a farce. (The author is reminded here of an incident between herself and a member of the U.S. diplomatic mission in a country abroad. The conversation occurred in the mid-1960's and during the stirrings of the Civil Rights Movement. The gentleman, who happened to be white, and this writer, were holding forth on the subject of the current unrest of the Blacks in the U.S. He in great sincerity suggested that whites could be more tolerant and accepting of Blacks if "we would only clean up our streets." It is obvious that he and others like him cannot understand that if you are poor, ill-fed, ill-housed and under-served, cleaning up paper, bottles and other debris on the street may not be a very basic need. So it is with the national policy on primary prevention of drug abuse--peer and cross-age tutoring, role playing, outward bound activities--will not put one slice of bread on the table not buy baby a new pair of shoes.)

A review of the findings reported in the publication, Social Indicators of Equality for Minorities and Women, /7/ documents the above position. Indicators are presented for different aspects of education, employment, income, and housing for men and women in the following groups: American Indians, Alaskan Natives, Blacks, Mexican Americans, Japanese Americans, Chinese Americans, Philipino Americans, and Puerto Ricans. The social indicators presented in the report provide clear documentation of many continuing and serious problems of inequality afflicting the groups studied. Some examples are:

Delayed Education.--In 1976 the percentage of women and minority men 2 or more years behind the average grade for their age was approximately twice the percentage for majority males. Most groups became relatively more delayed from 1970 to 1976, indicating increased inequality.

The minority concern in the field of education is getting an education. The majority seem concerned with truancy and run-aways; minorities with push-outs, throw aways or being classified as mental retardates.

High School Non-Attendance.--Young people in some minority groups are at least twice as likely as majority males to be out of school at this important stage in their development.

The drug abuse professional for the dominant society stress health curricula or drug information which address drug issues in the school setting. The minority communities realize that this approach will allow a highly vulnerable and at-risk segment to go untouched and in ignorance of the consequences of drug abuse. A further note regarding the general effectiveness of information as a prevention strategy must be added. Vincent Myers'/8/ work reveals that readily available and pertinent information about durgs has not been internalized among young minority groups. According to him, drug information materials are either written in standard English or Spanish which may not be attended to or understood by young people from oral and aural subcultures. These materials may also be presented in audio-visual forms in which minorities and other low income groups are excluded (e.g., Reading, Writing & Reefers). If the gaps in drug knowledge are to be closed, drug abuse information must be presented in forms which are suitable to the interest and experience of minorities. They must be in forms to which they can easily relate.

Housing.--Minorities are more likely to live in central cities than the suburbs where majority headed households are found, less likely to be homeowners, more likely to live in overcrowded conditions, and more likely to spend more than a quarter of their family income on rent.

There are research findings which show that within the majority culture there is a strong possiblity that children may be introduced to drug use by older brothers or sisters. Given the housing conditions just described it is probable, even more likely among minorities, that behavior of older sibs will be witnessed by and thus copied by younger children.

Income and Poverty.--Minorities are more likely to be unemployed (especially if they are teenagers), to have less prestigious occupations, and to be concentrated in different occupations than majority males. With regard to income, minorities have less per capita household income; lower earnings even after such determinants of earnings as education, weeks of work, age and occupation prestige have been adjusted for; smaller annual increases in earnings with age, and a greater likelihood of being in poverty.

Individuals experiencing these conditions are prone to respond with frustration, pain, powerlessness, lack of hope for change, and alienation. All of

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/7/ Social Indicators of Equality for Minorities and Women, A report of the United States Commission on Civil Rights, Washington, D.C., 1978.

/8/ Vincent Myers, "Drug Related Cognition Among Minority Youth," J. Drug Education, Vol. 7 (1), 1977, pp. 53-62.

these have been identified as correlates of substance abuse activity--using substances to escape or dilute such feelings. Climbing Mt. Everest or rappeling down the Grand Canyon may indeed be appropriate alternatives to drug usage by the bored teenager in Montgomery County, but is hardly an appropriate substitute to being poor - unemployed - underemployed.

Similar conclusions were reached by the Task Panel on Special Population of the President's Commission on Mental Health. /9/ This Panel's views indicate the important linkage between psycho-social factors and healthy development.

> The primary avenue to reduction in prevalence and incidence of mental disorders in the Black (minority) community is not professional services to individuals but changes in society at multiple levels. Data suggest that a certain level of income, housing, employment, educational opportunity, health care, for example, are requisite conditions to the prevention and maintenance of optimism, positive self-esteem, and general mental health. Blacks (minorities) face specific problems at every point in the life cycle so that the greatest promise is in prevention programs keyed to needs at each phase.

Ethnic Concerns About Prevention Strategies

Implicit in all the preceding has been ethnic concerns about national prevention policies and programs. There is one concern that needs specific highlighting. It arises out of the Institute's interpretation of the Federal Government's need for measures of the cost effectiveness of funded activities. It is the concern of minorities at prescribed impact measures or evaluation of programs. Minorities report that all too frequently program evaluation has meant a loss of program funding. Not because goals and objectives were not met, but because results were not expressed in terms of statistical significance or levels of confidence.

Congress has a need to know that tax payer's dollars are being spent wisely and for worthwhile causes. Our policy makers, however, are reasonable men and women. There are ways of documenting outcomes/program results that do not require employing an experimental design or control groups or random sampling that would be acceptable, it is believed, to the Congress.

The senior level managers who aware grants and contracts should be satisfied with good evidence that the programs are doing what they originally claimed they would do. Sometimes this evidence may come from taped interviews of participants or relatives of participants. The evidence could be as simple as attendance records of recipients in a particular activity. The application of sophisticated statistical procedures does not make a good program better or a bad program worse. Minorities feel, in many instances, that prescribed evaluative techniques are simply one more obstacle put in the way of their receiving services.

/9/ Task Panel Reports Submitted to the President's Commission on Mental Health, Volume III Appendix (Washington, D.C.: Government Printing Office, 1978), p. 743.

At a recent workshop held in the District of Columbia for minority prevention professionals this latter perception was voiced most frequently. In essence, members were saying that they had been encouraged by getting program funds; pleased at having learned how to write proposals in language acceptable to funding agencies; satisfied at the progress being made and the goals and objectives achieved. Then when they felt they had mastered the twists and turns of the funding maze, the rules were changed. Now programs would only be funded if an evaluation component were included. The evaluation component would be judged, it seemed, on the basis of level of sophistication. Never mind that service delivery would be interrupted, if not terminated. No matter that clients would be lost for lack of a regression equation--a coefficient of reliability. To receive funds, it seemed, it was necessary to administer the MMPI to Native Americans - Mexican Americans - Asian Americans - Blacks, Puerto Ricans - in pre and post test designs. To provide services, the criterion of need is second to the criterion of utilizing an identified, reliable and valid instrument. The intuitive rejection of prescribed evaluation strategies by minorities gains a measure of support from recent published statements of "experts" or "scholars."

Schulberg and Perloff took a look at the state of human service delivery program evaluators. Some of their findings were:

-- The traditional source for program evaluators has been academically educated researchers who have learned to use experimental techniques and statistical analyses to investigate theoretical issues but rarely have acquired skills needed for improving service delivery.

-- Evaluators trained in experimental design, when required to assess services and suggest policy directions, may use methodologies and instruments better suited to controlled laboratories than a chaotic organization.

-- Untrained researchers faced with assessment of services may derive unwarranted conclusions from studies possessing neither internal nor external validity.

-- Most graduate programs use the research or clinical training models, neither of which is directly relevant to evaluation training.

-- Few academicians appreciate the conceptual and methodological differences between generating new knowledge and evaluating existing programs and innovations.

-- Evaluators must recognize the practical and conceptual implications of choosing among the amelioration, accountability, and advocacy program evaluation models and the ethical dilemmas contained in each.

-- Gathering data for program-specific decisions and for broad issues may require a variety of evaluative designs; e.g., case studies, quasi-experimental, legal adversarial approaches, etc. /10/

/10/ Herbert C. Schulberg and Robert Perloff, "Academia and the Training of Human Service Delivery Program Evaluators," American Psychology, Vol. 34, #3, 1979, pp. 247-254.

The next quote very accurately reflects the conclusions of minorities:

> Sound scientific study refers to the logic of design, observation/measurement, analysis and interpretation. But we must avoid the mistake of assuming that if a research tool is complicated, quantitative and esoteric it therefore must be sound. You buy complexity, quantification and precision at a cost in constraining assumptions, limits to generalizability and increases in artificiality. /11/

Just as minorities know the burden of oppression and racial discrimination without the assistance of measuring tools or evaluative research, they are also aware when this burden has been lessened. The growth in self-esteem that comes with getting a job, knowing one's voice is heard. Being able to make demands may not be reflected on the Tennessee Self Concept Scale (which is irrelevant anyway to the individual who has discovered inherent strengths and ability).

Once again the different circumstances from which minorities and dominant members of the society operate need to be weighted to understand the different attitudes held toward evaluation. Given the rather obscure nature of stresses leading to drug abuse behavior among whites, there would have to be some urgency to discover which strategies best influence such behavior or which aspect of a given program influences which aspects of its recipient. It is reasoned here that the psycho-social stresses for minorities are blatantly apparent and the urgency is directed to alleviating these stresses. If it can be demonstrated that a program results in keeping children in schools, or in day care centers so that parents can work; in their homes rather than with foster care parents or in institutions; program activities provide young people with marketable skills; appreciation of their unique culture, value systems and beliefs, recognition and respect for survival skills - street smartness, then such programs would be viewed from the multi-cultural perspective as primary prevention.

Evaluative strategies must be considered within the context prescribed by Bush and Gordon:

> We have to decide in each particular case not only whose view more closely represents the situation but also who will be most affected by whatever service decision is made. The professional (evaluation specialist) who prevails over a client (program manager) for reasons no other than his/her possession of well tested knowledge has won an encounter for one version of the truth or less dramatically, for the professionals' right not to be unduly challenged or inconvenienced. The client who loses such a battle will have lost things the client considered vital to his/her well being. /12/

/11/ The Editor's Page, Journal of Social Issues. Vol. 35, #2, 1979.

/12/ Malcolm Bush and A. G. Gordon, "Choice and Accountability," Journal of Social Issues, Vol. 34, 4, 1978, p. 42.

In short, the Ph.D., academically-trained researcher has been trained to appreciate a special way of defining truth. For a program manager to disagree with what is considered his/her specialty is annoying. When the expert disagrees with the program manager's perception of Truth, human wastage may result.

This is not an argument to do away with evaluation. It is a plea for appropriate recognition of the complexity of the primary prevention concept. As Caplan points out, the goals of prevention efforts are rarely single and simple, they are usually multiple and complex./13/ Problems of specifying and obtaining adequate controls are also difficult. What may seem to be objective data may be dependent on unseen and unstudied subjective factors of both recipient and families, and of professionals. The authors acknowledge that different methods of evaluation will be appropriate for different programs. In some cases, subjective reports by clients of increased self-confidence or decreased familial discord will be appropriate; in other cases clinical judgment of the degree of personal growth and development or professional assessment of increase in I.Q; and for still others, lowered rates of homocides. To reiterate, from a multicultural perspective, counting the number of adolescents who have secured employment or for that matter, the number of eligible families who have been taught how to secure food stamps are valid indicators of the efficacy of primary prevention programming.

The writer adheres to the position that political-social factors, and not the individual minority member, are the primary foci for prevention programs. Equipping minorities with the wherewithal to successfully maneuver through a system which constantly rebuffs them is a germane goald for primary prevention programs.

Finally, awareness of ethnic's concerns in primary prevention can be drawn from previous conferences, workshops, task force meetings and the like. Anyone taking the pain to read the proceedings will find themes repeated in gathering after gathering. Some of these are listed:

Prevention Issues

Prevention, a service intervention strategy which has the potential for improving the health of all people in our society, has not been sufficiently supported by policy or funding. Racial minorities in particular are especially in need of additional community-based prevention programs. Therefore, it is recommended that:

1. The Alcohol, Drug, and Mental Health Administration (ADAMHA) develop a comprehensive list of racial minority prevention specialists to include: consultants, researchers, practitioners, and advisors who could contribute to the prevention strategy of ADAMHA.

/13/ Gerald Caplan and Henry Grunebaum, "Perspectives on Primary Prevention," Arch. Gen. Psychiatry, Vol. 17, Sept. 1967, pp. 331-346.

2. ADAMHA and its Institutes immediately promote racial minority prevention programs which would:

    a. Develop preventive strategies relevant to socio-cultural factors for implementation by state, county, and local mental health programs;

    b. Develop prevention materials relevant to each particular racial minority community, appropriately designed in the languages and "dialects" of the various monolingual and bilingual racial minority communities.

    c. Develop training programs in prevention for treatment personnel based upon the conceptual theory and practical skills relevant to racial minority and socio-economically oppressed people; and

    d. Develop specific "coping/survival" skill curricula applicable to each racial minority group in primary and secondary education levels.

3. ADAMHA provide the Minority Advisory Committee with a report on the current status of ADAMHA's efforts to ensure relevant prevention for racial minorities.

4. ADAMHA initiate the drafting of legislation which would require ten percent of Community Mental Health Center (CMHC) funds to be utilized for primary prevention programs and public health strategies. /14/

The recommendations of the Minority Group Alcohol, Drug Abuse and Mental Health issues' Conference have been presented verbatim. It is hoped that by continuing to emphasize these recommendations, additional movement toward achieving these objectives will be made.

A recent issue of the ADAMHA news quotes the ADAMHA administrator as stating the "the mental health field should confine its intervention to activities based on accepted concepts of public health, scientific evidence, and the profession's social mandate to perform specialized tasks." /15/ Changing the societal context in which minorities live is clearly beyond the province of mental health services and providers. Advacacy within the mental health field can, however, lead the way toward improving the quality of the social milieu.

An effective multi-cultural approach to drug abuse, alcohol abuse and mental illness prevention must incorporate the recommendations made to the President's Commission on Mental Health by the Special Populations Subpanels on Health of Black Americans:

1. Full employment achieved through the initiatives of the public and private sectors, and equal access to jobs assured by the continuation of affirmative action legislation.

/14/ National Conference on Minority Group Alcohol, Drug Abuse and Mental Health Issues. Conference Proceedings. May 22-24, 1978, Denver, Colorado.

/15/ ADAMHA News, Vol. V, #14, July 13, 1979, p. 1.

2. Affirmative action in the distribution of housing funds and opportunities for adequate housing.

3. Redistribution of health care facilities, with particular attention to primary prevention, and (2) improving access to quality health care.

4. Implementation of public welfare services that concentrate on the elimination of poverty and which support and supplement the initiatives of individuals to be participants in American society.

5. Lack of professional health and social manpower is a serious problem for minorities. Strong emphasis must be placed on manpower and scholarship programs for minorities so that they can assume responsibility for their own destiny.

In conclusion, professionals in drug abuse prevention, particularly those who have focused on the problems of ethnics of color, will have found little new or particularly exciting in this paper. I have not tried to be conclusive, inclusive or comprehensive. I have tried to underscore the work that needs to be done. There are enough studies and surveys by well intentioned professionals of all persuasions for us now to put aside further "research" and get with the program; we know abuse exists, we know where it exists, we know among whom it exists, we know that universal panaceas exist but do not work and, finally, we know that implementation of the recommendations in this paper can be delayed no longer.

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THE DEVELOPMENTAL APPROACH TO PREVENTING PROBLEM DEPENDENCIES

Paper developed by H. Stephen Glenn and Joel W. Warner, Social Systems, Inc., Bloomington, Ind., 1977.

Since the Department of Health, Education, and Welfare was formed during the Kennedy administration, it has steadily grown to the point that it has the second largest budget of any department in the Federal government.* One of the major reasons for the size of this department is the increasing social difficulties being experienced in the United States.

Recounting the difficulties we are facing is not the purpose of the present discussion. Suffice it to say that the trends have been consistent and very clear for fifteen years. One of the major concerns with which we are faced is the recent acceleration we have seen in these trends. Examples of some of the difficulties we are seeing include enormous increases in alcoholism, especially among women and teenagers; increases in juvenile delinquency ranging up to 300% in some areas; suicide becoming the second leading cause of death among teenagers (accidents rank first) and the leading cause of death among college students; extreme overcrowding in prisons, including erecting tent cities in some Florida prisons; a virtual doubling of chronic, long-term tranquilizer use by the general population, but especially among middle-class females.

The list goes on, but taken totally, clearly indicates that there are serious difficulties in this culture. The predominant response to the kinds of problems we have listed here has been to create more and more programs aimed at remediating the difficulties through applying some sort of treatment regimen to the person having the problem. Thus it is that we have created drug abuse programs, rape programs, vocational programs, alcoholism programs, child abuse programs, suicide prevention centers, and so on. There seems to be at least one program for any difficulty a person may get into.

These programs have proliferated at an astonishing rate. They also appear to share at least two important characteristics. The first characteristic is that they approach the problem from a remedial point of view. They work with people in trouble, whether they are in crisis or have a chronic, longstanding problem.

The second characteristic is that they see the problem on which they are working as somehow unique. They see themselves as working with, for example, drug addicts, which takes special skill or experience that others don't possess. This has the effect, among other things, of making certain people experts in doing therapy on a certain type of client. This also has the effect, unfortunately, of keeping different programs from working together closely--and tends to proliferate the number of programs we have.

The focus of this paper is not in the direction of either of these two program characteristics. Rather, the thrust of this is often at two odds with the assumptions and thinking which lead to these characteristics. Stated shortly, the widespread acceptance of these program characteristics has gone a long way to hamper efforts in directions which we feel not only need much consideration, but may be mandatory if we ever hope to reverse the trends which are so prevalent.

This is not to indicate that programs with a remedial focus are not needed. Indeed they are. The problem arises when we have only remedial programs.

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*The Department of Defense continues to have the largest budget.

That we had only remedial programs was acceptable when only a few persons were having problems and we could attribute such difficulties to some defect in the individual. As more and more people exhibit behavior which remedial programs were established to address, we must begin to question.

What has happened (or not happened) which results in so many people not being adequately prepared to live productively? Currently about one-third of our population receive remedial social-psychological assistance from some government sponsored or private "helping" institution. At this point, we believe it is necessary to begin to put a significant portion of our effort in "helping" before people experience problems. We speak of this as "habilitation" or prevention as opposed to "rehabilitation" or treatment. While the latter is, of course, needed, it would be far less needed were we doing a better job of preparing our citizens to live productively.

To discuss this in an orderly fashion, we will break the material into sections. The sections will consider the following topics.

1. The nature of the problem. In this section we will define the problem succinctly and include a developmental profile of the high-risk individual. It is in this section that we will outline the necessity for more generic approaches to both prevention and treatment. By generic approaches, we mean programs and approaches which work with the individual as such, and are not committed to working with just alcoholics, juvenile delinquents, Valium users, etc.

2. A systematic approach to prevention. Though there is not widespread understanding of what exactly prevention is, we will discuss it as an activity or set of activities which promote the development of necessary life skills. It is in this section that the role of the family, school and community will begin to come into the spotlight as major positive or negative influences in the development of young people.

3. The family as an habilitative structure and the school's role in socialization. The family traditionally has provided experiences which greatly aided a young person in preparing for life. The recent incursion of technology and urbanization into our culture has altered the family's ability to provide these experiences. This section will discuss the family's role, how that role has been interfered with and what sorts of adjustments are necessary to reinstate the family as a potent habilitative force.

The school has the potential to be a potent force in preparing young people to avoid difficulties. Too often, however, the school has become the focal point of many of our difficulties. The school has been saddled with many parental responsibilities, and yet often does not understand the underlying developmental principles upon which effective socially oriented educational programs must be based. This section brings some definition to these controversial elements by concentrating on processes which enhance the life skills of students.

4. The community as a positive supplement. Because of diverse notions of "community," it is hard to talk in terms of either community responsibilities or strategies which "the community" can implement. In this section, therefore, we talk of generic community-based programs and the types of things which can be accomplished by these programs. We will also discuss the type of training and insight which will most benefit the leaders in these programs.

THE NATURE OF THE PROBLEM

As stated previously, one of the difficulties we have faced has been that our social problems have been seen as being discrete and unrelated. This is beginning to change. The first impetus for this change came from observers who began to notice similarities used in a broad range of treatment programs. Since that time, more focus has been brought to this view, including the realization of the remarkable similarities between the clients in a wide variety of programs.

In recent years, observers have noted a steady convergence of effort and insight around a set of underlying processes that describe most prevention, treatment, and rehabilitation programs and correlate closely with the identifiable characteristics of the at-risk population. This body of research which focuses on the dependent behavior of the individual and on his interaction with his environment increasingly describes a set of developmental characteristics that consistently characterize the most typical client in social programs. Research findings for different populations suggest that similar developmental characteristics describe the narcotic addict, the physician addicted to Demerol, the executive addicted to alcohol, the chronic recidivist in the criminal justice system, and the most typical high school dropout.

While explanations of the causes of dependent behavior vary considerably across disciplines (i.e., medical, psychological, sociological, cultural, economic, legal, etc.), the resultant outcome in terms of an individual's learning or developmental profile appears to be quite consistent.

Developmental Characteristics

In general the "high risk" individual shows significant inadequacies in one, several, or all of the following areas:

1. Identification with Viable Role Models. This refers to a person's reference group and self-concept. The vulnerable person does not see himself as like (or the same as) people whose attitudes, values, and behaviors allow them to "survive" in their total environment.

2. Identification with and responsibility for "family" processes. In this context, "family" is used in a broad sense. It can and does often mean the traditional nuclear family (Father, Mother, 1.8 children, dog, cat). It is also used to mean family in the sense of broad organization, living settings, group identifications and so forth. When this identification is poorly developed, a person does not identify strongly with things greater than himself (e.g., relationships with another person, in groups, mankind, God, etc.). He does not see that what he does affects others. This refers to shared investment in outcomes, shared responsibility for achieving outcomes, and accountability to others for behavior.

3. Faith in "miracle" solutions to problems. This refers to the skills and attitudes necessary to work through problems and believe that they can be solved through application of personal resources. When poorly developed, a person believes that problems have been escaped when he can't feel them any more. (This is often through the use of alcohol or drugs.) He does not believe that there is anything he can do about the present or future, things just happen to him.

4. Intra-personal skills. Intra-personal skills are those which a person uses to communicate with self. This refers to the skills of self-discipline self-control, self-assessment, etc. Weaknesses in these areas express themselves as: inability to cope with personal stresses and tensions; dishonesty with self, denial of self, inability to defer gratification, low self-esteem, etc.

5. Inter-personal skills. Inter-personal skills are those skills which enable a person to relate to or build a relationship with another person. Specifically, they are the ability to communicate, cooperate, negotiate, empathize, listen, share, etc. Weaknesses in these areas express themselves as dishonesty with others, lack of empathic awareness, resistance to feedback, inability to share feelings, give or receive love or help, etc.

6. Systemic skills. This refers to the ability to respond to the limits inherent in a situation (responsibility); the ability to modify behavior according to a situation in order to get one's needs met constructively (adaptability), etc. Weaknesses in these areas express themselves as irresponsbility, refusal to accept consequences of behavior, scape-goating, etc. A person with low skills in these areas tends to see himself as a victim of circumstances.

7. Judgmental skills. Judgmental skills include the ability to recognize, understand and apply relationships. Weaknesses in this area express themselves as crises in sexual, natural, consumer, and drug environments, repetitious self-destructive behaviors, etc.

Most human behavior is a composite of the seven areas described above. Social norms define acceptable forms of behavior, and require certain levels of functioning in each of these areas. By assessing levels of functioning or development against norms, as socially and environmentally defined, these developmental characteristics are used as diagnostic indicators of "high-risk" and "low-risk" populations for purposes of both prevention and treatment. At present treatment and prevention programs have both explicit (expressed) and implicit (implied) goals which reflect the above characteristics. An analysis of these goals suggests that, in virtually all* current approaches to prevention, rehabilitation and therapy, workers are attempting to establish or maintain situations in which their clients, through practice and experience, can:

- Strengthen or develop intra-personal skills
  (get self together)
  and/or

- Strengthen or develop inter-personal skills
  (learn to deal effectively with others)
  and/or

- Strengthen or develop systemic skills (learn to handle situations)
  and/or

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*There are some treatment approaches, such as free-standing detoxification programs, which address only the medical needs of the client and therefore do not address themselves to these issues. As a matter of policy, however, most treatment programs are required to provide supportive services which do embrace these issues.

- Develop judgmental skills (learn to make decisions and recognize what's going on)
  and/or

- Strengthen identification with and responsibility for "family" processes (become part of something greater than self and learn to carry his/her own weight)
  and/or

- Strengthen identification with viable role models (learn to see self as the kind of person who is making it and identify with others who are also)

Prevention and rehabilitation workers at all levels have an increasing need to know these developmental processes and be able to:

1. Model appropriate behaviors.

2. Assess a client's needs in each area.

3. Provide experiences and supportive processes necessary for growth and development.

4. Monitor and evaluate progress.

The following brief points highlight the state-of-the-art in treatment, prevention, research and evaluation, and policy and planning with respect to the above processes and constraints.

Treatment Services

In spite of Federal policies heavily concentrated on remedial programming, the range of treatment and rehabilitation services has steadily broadened in response to different levels of social and practitioner awareness. At the present time treatment is characterized by a tremendous diversity of program modalities and therapeutic techniques. In the light of the foregoing discussion, this may appear to be a potentially healthy trend. However, a careful analysis of this situation indicates that workers, in general, are using therapeutic techniques or programs to treat symptoms and are failing to focus consistently on developmental processes in working with dependent persons. (Often the program is emphasized at the expense of the generic developmental processes.)

The literature of clinical research clearly indicates that reliance upon a single mode or approach to therapy (even under optimal conditions) meets the need of a very small percentage of clients. On the other hand, adherence to generic principles or the eclectic use of therapeutic resources greatly increases clinical effectiveness. Resources now exist to greatly increase treatment effectiveness. What is needed, however, is an articulation of generic principles and the mastery of related skills by clinicians in order to reduce levels of dependent behavior in the client. It is interesting to note that a number of States, recognizing this need, have already begun to training couselors in dependency-centered, developmental approaches to substance abusers.

There is, therefore, a pressing need for:

- Programs which are hospitable to the client and compatible with his lifestyle and developmental needs.
- Counselors who are able to model appropriate behavior, respond sensitively to the range of developmental needs of clients, assess growth and development, and structure or select appropriate responses at different points in time and at different levels of development.
- Program administrators and support personnel who are able to achieve and maintain maximum flexibility and accountability within program structures.
- Medical personnel who are familiar with developmental and learning processes and able to provide supportive medical treatment when necessary.

All of the above reflect levels of understanding on the part of treatment workers. The great majority of workers have come into the field either as clients or entry level counselors who are familiar with, and often committed to, a single program or modality. This factor is largely responsible for some of the limiting conditions described above and underscores the pressing need to train treatment workers in generic principles and developmental processes.

A SYSTEMATIC APPROACH TO PREVENTION

While there is no universally accepted definition of prevention, there is a steadily increasing body of knowledge about prevention and "successful" prevention approaches. The findings indicate clearly that developmental processes similar to those outlined as important considerations in treatment are also of paramount concern in primary prevention activities.

As an example, workers in the field of prevention generally agree that substance abuse is one behavior (among many) in which the individual, poorly prepared to make good judgments, makes judgments that precipitate crises. This leads the poorly habilitated person to expressing his dependence as addiction or drug dependence.

Recognizing this fact helps to explain why cognitive (i.e., factual) anti-drug programs have been successful for only limited numbers of individuals. Such an awareness also helps to explain the emergence of more developmental family, educational, and alternative programs that seek to strengthen the individual and enhance his potential within society.

There is also a growing distinction between drug education and primary prevention. Drug education must go beyond facts of illicit drugs and prepare a person (including medical practitioners) to be a careful and sophisticated user of illicit substances, capable of making good judgments and thereby avoiding crises, both medical and legal.*

At the same time, such educational activities must be supported by primary prevention activities that focus upon attitudes, values, and developmental characteristics of the individual. Briefly stated, primary prevention consists of activities in the home, school, and other institutional settings, peer group, and community, that provide opportunities and support for the developmental goals outlined in the last section.

These goals are either implicit or explicit in most of the prevention programs which have been identified. In programs as diverse as the Gloucester Project in Massachusetts (which uses local pride and the restoration of community historic sites to accomplish the above goals), to the PAR (Parents Are Responsible) program in South Dakota (which teaches parents how to provide this preparation for their children), the processes associated with these goals are apparent. However, prevention workers, like treatment workers, often confuse the program activity or context with the inherent developmental processes. This often leads to defining the prevention program as a success based on the activities, per se, and they thereby fail to maximize the program's potential.

At present, there is a pressing need for educators who can provide training in making judgments. There is also an immediate need for prevention workers who understand developmental processes and who can, because of their ability to provide essential growth and development for their participants, strengthen and support:

- families;
- education programs;
- community and alternative programs; and
- institutional programs.

Research and Evaluation

A wide range of technical and research tools currently exist for measuring or assessing change in attitudes, values, and behaviors. In a number of areas, researchers are beginning to focus upon developmental characteristics of certain subsets of "at risk" populations and have produced many of the insights previously referenced. But to date there has not been sufficient interchange and eclecticism to develop and test general field theories.

In the area of program evaluation, the primary emphasis has been upon data reporting systems, cost effectiveness, and upon the achievement of social goals and funding objectives. As a result of these pressures, the field is only just beginning to develop measures of program effectiveness that focus upon the individual recipient of services. Such developments have also been hampered by the confusion over programs, therapeutic modalities, and developmental processes.

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*This expanded emphasis is based on the overwhelming dominance of licit substances involved in drug crises (70-75% according to DAWN) and dependencies (alcohol-tranquilizers-barbiturates, etc.) and the need for a more knowledgeable consumer of medical services. (Recent studies indicate that over-prescription and unnecessary prescriptions constitute a major health hazard to Americans.)

There is a need to increase the capability of research and evaluation manpower to assess developmental characteristics of the individual clients and then develop instruments and procedures for monitoring and evaluating growth and development in these areas. There is also a need to increase the skill base in implicit goals analysis of program, practitioner and client performance.

THE FAMILY AS AN HABILITATIVE STRUCTURE AND THE SCHOOL'S ROLE IN SOCIALIZATION

Neither reading about it nor wishing for it gives a person a skill. Skills are acquired through practice. Practice relevant to developing human relations skills is called interaction. One has to have interaction in order to develop skills for dealing with self, others, and social situations.

At birth a child has no skills. Initially the infant has no learned behavior. By age eighteen society expects him to have acquired the necessary independence, self-reliance, and socially responsible attitudes, values, and behaviors for every conceivable adult situation which may confront him. This is his legal assignment; this is what he is accountable for at age eighteen.

The institutions responsible for bringing the infant to this point are the home, the school, and (for many people) the church and other supportive institutions. These institutions are supposed to provide a life-guide that will direct his behavior. But those behaviors have to be learned. The home and the school (as a minimum) are to provide him with enough personal experiences in dealing successfully with himself, others and his environment so that at eighteen he is prepared to live responsibly. Of course, homes and schools do a lot of other things, but the development of responsible behavior is the preparation they are to provide. If this preparation is not provided, habilitation may take as long as an additional thirty years, or even more. Presently an estimated one-third of all persons reaching age eighteen require the services of some helping professional to eliminate some problem dependency in their lives. This is disturbing information.

These problem dependencies show up in a variety of ways (no longer to be thought of in terms of addiction to this or that) and are identifiable whenever the behavior of the person is dependent on some outside crutch. For instance, in a family sitation, a man may desert his responsibilities with the result that the family requires welfare counseling. Or a person may be fundamentally unemployable, and thus be dependent upon society because he does not have any relevant work skills. A youth may be an educational dropout. A person may be a chronic criminal offender, always in trouble for some kind of anti-social behavior. A person may be dependent on alcohol or drugs.

The alcohol dependent, the drug dependent, the hardcore unemployable, the educational dropout--these groups of dependent persons alone represent over thirty percent of the population now reaching age eighteen. When helping professionals are called in, if the way in which the problem dependencies have shown up is disregarded, it is found that each professional succeeds only to the extent that he sets up situations in which clients develop better skills for dealing with themselves, others, and the environment or situations in which they find themselves. Therefore, the professionals are all providing basically the same developmental support.

What is the implication, for the home and the school, of the fact that one person in three needs professional help to become fully adult in his judgment and behavior? It is simply that, for one person in three, the combination of home and school is inadequate to prepare him to function at the level required by society.

The amount of money which will be spent this year for the services of helping professionals is over fifteen billion dollars. This is seventyfive tax dollars per person per year. Every year similar amounts to into the effort to patch up problem dependencies. That does not include the costs of crimes committed, the value of things stolen, or the welfare received by dependent persons.

Why has this happened? If there was a time in recent history when the combination of home and school was adequate for almost everyone, that period might be compared to the present and the differences carefully noted. And the differences might also suggest some remedies.

In what follows, we will undertake to make this potentially helpful comparison of time periods. It will be noted as we proceed that urbanization and advancing technology have had great impact on our culture.

There was once a time in America when the attitudes, values, and behavior of each generation was passed on quite well to the next generation as the natural result of interaction between parents and child within the family unit. Almost without exception there was good cultural transfer as the child grew up living and working alongside his parents. By the time he reached the teenage years, if his parents were infirm or had died, a boy could step in and fill his father's role because he had been actively associated with it from infancy. In a similar way, a girl learned to take over her mother's role.

At sixteen or seventeen there were very few mysteries about being an adult and being part of the adult world. One reason for that was there was a consistent pattern of life for nearly all families. This was true in America until about 1935. Even in 1935, seventy percent of all Americans still lived in a traditional setting.

The lifestyle then was essentially rural for most Americans. However, the only pattern of interaction that was typical from family to family was the pattern of working together.

In all probability a child would work for at least ten hours of the day alongside one or both of his parents. Almost from the time he was old enough to walk and speak he was there--solving problems, watching decisions being made, making decisions, learning about values, getting on-the-job training. He was a participant and not just an observer in the adult world.

Even though the sleeping hours were unavailable for interaction, there remained about six waking hours after the day's work was done. Some of the time was spent eating, and mealtime was very much a discussion time. Evening hours were also spent learning handicrafts, the skills of making things actually worn or used. There was typically singing, playing of games, and learning to read and write. There was much interaction between brothers and sisters, parents and children--all the family members, often including grandparents.

In fact, living in an extended family had important consequences. One had aunts, uncles, cousins, grandparents close at hand. If Dad came down on you very heavily, Grandma was there to say, "He was like that when he was a boy, too. But you had better go along and do what he says." So that the heaviest authoritarian discipline was rationalized and personalized for the child, with the result that he could understand it and accept it more easily. How important that was cannot be overlooked. A very authoritarian discipline system was possible because there were other adults to help it become understood. Also, everyone had chores in addition to the farm work. These chores were important personal responsibilities. If the child assigned to do the milking forgot to milk the cow for three days, the family went without milk until the cow had another calf. There were times when one had to give up doing what he wanted to do to go pull weeds. This was not busy work. If one did not pull the weeds, in three months there were no vegetables to eat. If one left home on a weekend, enough hay and water and feed for stock and pets had to be left. If the three-year old forgot to gather the eggs some morning, everybody discussed with her the importance of not having fried eggs or an omelette for breakfast. So responsibilities began early and increased as the family members themselves grew.

In the environment of that period, there was what would now be termed a great surplus of significant interaction within the family. Because of that, no one worried about habilitation. It just happened. It could be assumed that a child born in a home and growing up there would be like his parents with whom he spent all his time. Because of isolation the rural population had very limited access to information. Some parents had ambitions beyond the farm for their children but could not afford private tutors. Parents formed groups, pooled resources, and "invented" schools. But school was two to three hours a day once or twice a week because no more time away from farm work could be afforded by the family. The schools were institutions where persons of all ages met together to be taught to read and write by a teacher carefully selected by several parents. Quite naturally these parents chose a teacher whose values and behavior was in harmony with their own.

Together, these two institutions, the home and the school in a partnership, had the job of producing individuals prepared for successful living. The chief problems at that time, in view of the inadequacy of communication and the shortage of information, were illiteracy and a general lack of awareness on the part of the rural population. The school's job was to try to correct those two deficiencies. The school was viewed as a solution to a problem. That was its whole reason for being. And in that general setting, generation after generation grew up, and got educated. That was a life-style in which habilitation was a natural result of constant on-the-job training for adulthood.

Between 1935 and 1950--fifteen years--the most massive social change ever known in this country took place in an incredibly short time. By 1950, according to the census, seventy percent of all Americans lived in an urban environment, and only thirty percent on farms. A complete reversal had taken place in fifteen years.

By 1970, ninety percent of Americans lived in an urban environment, and even those living in a rural environment lived an urban lifestyle. They commuted to work, had television, etc. Thus in a very short space of time Americans made the transition which had taken nearly 400 years in Europe.

Consider the impact of this great social transition on the amount and quality of family interaction. As before, a sleeping period of about eight hours was unavailable for interaction. But beyond that fairly inconsequential similarity, there was an enormous change. Most important was the fact that urbanization virtually eliminated the likelihood that a child would work for any significant portion of his time alongside either of his parents. As a result, problems showed up almost immediately.

What could be done with children all day when they were not working or contributing to the sustenance of the family? It was decided that if a little school was good a lot more was better, and an eight-hour compulsory school day came into effect. It seemed like a good idea. Parents felt sure children in school were being looked after, and education was generally valued.

Among the assumptions of these early schools was that a quiet classroom was a good classroom. There was minimal interaction between students. Information passed from the teacher to the students. That was good for about an hour. But turned loose for a recess, they were everywhere. So educators, in an attempt to cut that disorder down to a minimum, had students change classes every fifty-five minutes, allowing them five minutes in which to do so. That way students would not be tempted to talk to each other because they had places to go. So the student's day was to sit quietly, run, sit quitely, run and so forth.

The next problem was lunch. Someone clocked the time spent by a student going from his last morning class to his locker and then getting and eating a meal perhaps consisting of a bowl of chili, a piece of corn bread, and a glass of milk. By the time he finished his lunch, returned to his locker, and got to his first afternoon class, the stop watch said twenty-five minutes. Therefore, twenty-eight minutes were allowed for eating and called a "lunch hour."

Then someone decided that starting students off to the lunchroom in shifts of ten minutes would really cut interaction down to a minimum. So there were shifts. Finally the hectic school day ends and the student runs out to the bus and sits down. He turns to talk to a friend, but the bus driver says, "Be quiet. You must not disturb the driver."

And there it is. It is an accepted fact that much of the scheduling is purposely designed to minimize interaction. The school day in no way replaced the interaction with significant adult role models and relevant life situations that used to take place during those ten hours a day on the farm. In fact, situations like this occur frequently: A child has a bad experience in his first period class. He cannot go up to the teacher after class to say, "Something you did in class today really upset me," because (a) teachers are not accountable to their students for the way they affect them; (b) the student could get run over by thirty to fifty others heading for the next class; and (c) if the student waits too long he has to go to the dean for an admission slip to get into his next class.

Of course he is frustrated. But if any of that frustration shows up in his next class he will be in trouble in two classes. He cannot stop to talk to any of his friends because they are going different ways. At lunch if he has to get a pencil for his next class, that is all he has time for after he eats.

For many youngsters, the only time they have to deal with the whole emotional experience of school is between three-thirty and five, acting it out on the streets with some of their friends while they wait for their parents to get home. In some cities (where schools are big enough), schools have become little more than minimum security prisons. Students bring guns to school. The teachers themselves are armed and protected. A terrible atmosphere has grown up.

Teachers trying to teach eight hours a day say the school day is too long. They need to break to sit down and regain their composure and collect their thoughts. Now they are adults doing something they want to do, for reasons they understand, for rewards that mean something to them, yet they need a break! The students, on the other hand, are in a place where they do not want to be, for reasons they do not understand, doing things they do not want to do, for rewards that come only every nine to fourteen weeks in the form of a report card, which may only matter when it is discussed with parents.

A five-year old, in one year, gets more of the world's total experience, intellectually and emotionally, than her grandfather got in his entire lifetime. She does not lack information. All she lacks is his wisdom, judgment, skill, and maturity to make sense of the information. Still some school people think it is their job to find better ways to give children more and more information. There now is the most massive surplus of information ever experienced in any period in world history.

The major problem today is not illiteracy. A totally illiterate person can get more information in a half-hour than a scholar could get in a month thirty years ago. With regard to social awareness, an hour in front of the television at news time can contribute more than any school can in a similar period.

Can the school, in its new role, help people who come to it unskilled in such vital matters to work out where they are and where others are and to learn to respond with appropriate behavior in situations that face them? That is what family and community interaction used to provide.

The situation seems reasonably clear. In less than thirty years the issues facing society have been completely reversed. Though changes have been made in American lives, the assumptions about how to raise children or how to educate them have not been changed. Parents still expect their children to be like them. Persons still think education reduces to teaching pupils to read, to write, and to do arithmetic. Yet we are confronted with a massive change that has made these assumptions very questionable.

In rehabilitation a lot of money is being spent to take people who lack relevant life experiences and try to give them those experiences "retroactively." This is both wonderful and sad--wonderful because it can be done--sad because it has not yet been done widely enough. With a slight change in priorities relevant life experiences can be provided when they should be. By consciously providing appropriate experiences to children in their early years--habilitating them--the necessity of rehabilitating them when they are 25, 30, or 50 is done away.

Living on a farm is not the crucial structure. Life in the city can be richer if the process by which we pass life experience and understanding on to children is not neglected or abandoned.

In a certain study, adolescents were asked, "What does your father do for a living?" They could give his title, and the day on which he brought home his paycheck, and that was all. Most had not a clue what kind of pressure he was under, what kinds of decisions he had to make, the people he worked with, whether he got angry or not, or even what he actually did. How comfortable can such youngsters feel at age eighteen stepping out to assume an adult role with such poverty of direct experience and knowledge? Children now, in most essential areas, are almost always observers rather than participants in the adult world. Most of their responsibilities have been taken away from them.

Parents want to have obedient, cooperative children. They tend, for example, to command their children to help instead of teaching their children the consequences of not helping. They say, "Don't do that," but they, the parents, are then the only ones who know what was wrong. On the other hand, by saying, "What might happen if you keep on doing that?" the child would have to think about it himself. He might see the danger for himself. He may need some helpful guidance in the form of additional questions that might help him see the danger. But eventually he will gain the insight. He will have learned something that might help later when his parent is not there.

The more parents and teachers push their will, the less responsibility the children have. Instead, parents and teachers must learn to give children the opportunity to plan and to do things for themselves. A therapeutic community does exactly those things that parents could do at home in a few minutes a day.

If ten new clients were asked to do something like make enough tunafish sandwiches to feed the whole therapeutic community, five of them would freak out right there because they were afraid that someone would laugh at them or that they would do something wrong or that people would not like the sandwiches, etc. In other words, they have had so little experience with failure and have such limited self-concepts that they cannot handle minor responsibilities.

If the five who are able to rise to the first challenge were provided with another challenge, such as to prepare a menu for the next two days, three more would drop out because they have never thought of tomorrow in that much detail before. The two who survive these first two challenges would usually fail a challenge such as shopping when hungry because they are generally unable to put aside what they want to do long enough to do what they need to do and would return without essential items.

The rehabilitation process begins by trying to provide ten people with experience in success and failure so that they can take the risk, in this case making sandwiches. Five people are then trained to think about tomorrow in enough detail to allow for it. And then if the process goes very well they may be helped to learn enough self-control to put what they want to do far enough aside to allow them to do what they need to do.

Schools now have the child for well over half of his total developmental time but do not provide relevant life experience through which life skills, social skills, and societal values are transferred. As the amount of time available to a child for this interaction diminishes, the importance of the remaining time is multiplied. Certainly the remaining six hours after sleep and school is now most significant. But is that time adequate?

In 1948, a technological innovation was introduced that was destined to have massive social impact, an invention that would profoundly affect human culture, society, the world. It would eliminate many of the natural effects of time, space, distance, cultural differences, language differences, value systems, and especially role models of the isolated family. That invention was television.

Television, with all its good effects, has also brought into the average home attitudes, values, and behaviors completely foreign to those exhibited by the parents. Television is a tremendous influence in the home as a source of attitudes, values, and behaviors. Whether the children accept or adopt them or not, they are made aware of them.

But the most significant thing is the fact that TV has become the hub of social and leisure time in our society. In 1970 the average viewing time per person was five hours per day.

If work time and viewing time take an average amount of time, that leaves just one hour per day for family interaction. This leaves out mealtimes and the normal business of the family, but Americans are ingenious. They have discovered mealtime and viewing time could be combined. This is done at the expense of all the discussion and sharing that used to take place at the dinner table. Going to the neighborhood bar, washing cars, visiting friends, going to meetings, going to shows, all these things can now be replaced with TV in the rich environment of the living room. If a family diligently uses the remaining hour every day for meaningful interaction, that divides up into fifteen minutes per day for any two members of a five-member family--not a tremendous amount.

Thus, in less than thirty years we have gone from a society with a huge surplus of significant interaction between the generations, particularly within the primary family unit, to a society in which there is a critical shortage of that kind of significant interaction.

At the same time, school has been given pre-eminence. School was designed to give information to people. But to the extent it retains that as its primary goal, it may become the most hopelessly irrelevant antique ever created. It has been roundly replaced in this function by technology.

The tragedy is that for most of these clients this growth could have occurred at home and in school if our assumptions had been different.

With respect to the quality of experience in the home, lives must touch, experiences be shared, or there is no reference point. Parents frequently say, "I'm so afraid my sixteen-year old is using drugs." When it is suggested to them that they ask the sixteen-year old son or daughter if he or she is on drugs, they are panicky and say "Oh, no, I couldn't do that." Obviously it has been a long time since parent and child had a common reference point of any kind.

Communication is based on the fact that there is enough experience in our separate lives that is similar that when words are used they have similar meanings to both speaker and hearer. In the 60's a pronounced gap developed between two sets of life experiences, two different generations. For some it got so wide that the commonly understood words needed to cross it did not exist.

Yet hundreds of families raised hundreds of kids all through the stormy 60's without that much of a breakdown. The key to thier success was regular, at least weekly and often daily, patterns of shared relevant life experience within the family. Opportunities were provided for the children to participate in the management of the household and the planning of significant family events.

Each of us can see a whole lot of things we can do to cultivate independent, responsible behavior. Consider the quality of relevant life experience you are providing your children. Give them more and more opportunities to make decisions. Respect those decisions, even when they are wrong. Children need to make wrong decisions. Help them make those wrong decisions on youthful matters where the consequences are not that serious. Only by making some wrong decisions can they learn to make right ones.

This is the most relevant thing that can be done by parents for young people. It is not happening for very many of our children today. It does not take a lot of time. Even where little or no time is spent with children in family situations, two-thirds of the kids are making it. So it may take only a tiny amount of time.

Those families that have established regular patterns of interaction have the highest rates of transfer of attitudes, values, and behavior and the lowest rate of involvement with alcohol, drugs, and other emotional supports. Orthodox Jews in downtown Harlem have consistently turned out the lowest level of involvement with crime and drugs. And they do it in the worst possible neighborhood. To raise an Orthodox Jewish child requires a father who is willing to teach him responsibility, willing to help him develop in every aspect of his life.

This is what is needed. Children learn to be independent and face life successfully only by on-the-job training. Parents have got to find ways to make room for that training in the family as children are growing up. The alternative is to help them pick it up after a life has been ruined, a job has been lost, or a prison record has been established--too much of a price to pay.

There needs to be a shift in priorities in schools. For better or for worse, the school has the child about eight hours a day. In most cases the family will have him less than two hours a day. If it is going to be the family's job to do habilitation, then the school had better give the kid back to the family for eight to ten hours a day. If it does not, then the school is going to have to shift its priorities to provide more relevant life experience at the practical and applied levels.

All of the learning technology exists to do this. There are fine techniques and fine procedures. But before schools can be successful, a curriculum must be developed which emphasizes the developmental processes, including responsibility, goal setting, and accountability. The concept is beautiful. But in almost every State parents and educators are blocked by people with old assumptions about what education is. Parents are needed who understand children have to learn to make independent, responsible decisions. Schools have to be willing to help that happen.

If the objective is just to get information across, more can be done with technology in an hour than a school can do in a week of eight-hour days. What technology cannot do is provide a chance for a child to learn from a variety of other people, practice his social skills, and test out his ideas on others. That is a change schools should be helped to make.

THE COMMUNITY AS A POSITIVE SUPPLEMENT

As we discussed in the last section, urbanization and the urban life-style has had a tremendous effect on American life. One major change has been in the community. The concept of community has changed and the community spirit which led to cooperative projects and activities has all but vanished.

There have been many recent efforts, however, to use the community as a base for prevention activities. These activities are generally designed to meet one or more of the objectives described in the section on prevention. These programs often take the form of recreation, crafts or drop-in centers. To the extent that the programs emphasize developmental processes, they can be effective in assisting in the habilitation process.

Some programs, however, merely help a young person consume leisure time. These programs are not only ineffective, they can be detrimental by posing as an habilitative agency.

Another type of activity achieving positive results in the community is parenting classes or parent training groups. These groups generally focus on ways to enhance the quality of interaction between parents and children. Many of them also attempt to teach parents how to help children identify with and take responsibility for family processes.

These programs are usually either professionally sponsored, for which tuition is charged, or are run by local social service agencies such as the Community Mental Health Center. The very fact that such a movement exists is a sign that parents are becoming aware of the fact that, given better skills, they can make a more significant impact on the lives of young people.

Traditional Community Structures

Throughout the changes which have come to our culture, several organizations have continued to exist. The scouting-type organizations, for both males and females, have consistently been leaders in helping young people develop a variety of skills. They continue and are re-emerging with some adaptations designed to make them more relevant. Street Corner Scouting is one such adaptation.

There is a great need, however, for leaders of youth to become more familiar with developmental processes. It would be well worthwhile for local agencies in the helping field, such as mental health centers, to profitably become involved in training volunteer youth leaders in helping young people develop the skills outlined in the prevention section of this article. Such training could be accomplished during special sessions, at scout roundtables, or other administrative meetings. A few minutes devoted to one principle of assisting youth can be of great benefit if conscientiously applied.

All of the above applies equally well to other youth-oriented organizations. This includes such programs as Big Brothers and Big Sisters, Junior Achievement, 4-H, etc. A better understanding of the processes of development will enable leaders to better assist youth. Too often the activity itself becomes the overriding focus.

Churches

Churches traditionally have youth programs. These youth programs take many forms. From the standpoint of involving youth in developmental processes, some do fairly well while others are less worthwhile. The Church program, like that of the family, should be one where young people can experience both success and failure. They should learn to take more and more responsbility as they grow into it.

For example, a church youth program could adopt a policy of "shadow leadership." In a shadow leadership program, the adults stay in the shadows and perform mainly a steering function--helping young people stay on course. The youth would take the responsibility for planning and implementing activities, including taking turns chairing committees, doing administrative follow-up, solving the crises which come up, and so forth. One of the main problems these types of programs experience is adults stepping in at the last minute to rescue an event. This robs the young people of experiencing the fruits of their labors. By not allowing them to fail, the adults take from them some of the truly valuable learning experiences of life.

And Finally

The quality of people we have in our community is a product of the kinds of life experiences we have had. If we have been involved in developmental activities, if we have shared significant life experiences with adults in our environment, and, generally, if we have developed through our experiences the seven characteristics we have outlined, we will avoid many of the pitfalls and problems which are currently being experienced.

Our program, which is achieving very significant results, is a church-sponsored program called "Family Home Evening." In the Family Home Evening program, each family in the congregation is asked to set aside one night per week and devote that to family time. During this time the family engages in a variety of activities. These activities include recreation, family councils, service projects to others, and lessons. This need not, obviously, be limited to church organizations, but can be adopted by any family that is serious about providing each other with life experiences significant for a productive life.

During this Family Home Evening program, each member of the family takes turns planning activities, preparing refreshments, conducting meetings and giving lessons. In this process each finds not only new skills, but learns his or her place in the family and, consequently, learns that he or she is valued and valuable. Families who have followed this plan reap great rewards. Members of these families experience very few problem dependencies, low rates of juvenile delinquency, higher than average success rates in school, and many similar benefits. Such families also have remarkably low divorce rates (both among parents and among the children when they marry).

It takes conscientious effort to involve youngsters in these prevention activities. The nice part, however, is that this effort can be meted out a little at a time and, if done consistently, can have dramatic and profound impact. The opposite is also true. Families, schools and communities who persist in maintaining low-interaction lifestyles and neglect to involve young people in positive developmental processes also have a profound impact. The fruits they reap are remarkably similar to what we currently see in our society.

We are confident that most people are willing and able to have a positive impact on the lives of others. We are also confident that the processes are not mysterious. The most important need is conscientious effort in all parts of the community to recapture the processes which help young people develop skills, attitudes, and values which enable them to productively meet the challenges of life.

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TABLE ONE

LEVELS OF EXPERIENCE, MOTIVES, AND DRUG ABUSE PATTERNS

by Allen Y. Cohen

Reprinted from Alternatives to Drug Abuse: Steps Towards Prevention, National Institute on Drug Abuse, 1971.

Table One
Levels of Experience, Motives and Drug Abuse Patterns

Level of Experience: Type of Gratification	Corresponding Motives, Needs, Aspirations	Most Probable Drugs of Abuse
A. Physical: Pertaining to the general feeling of physical well-being, and experience of the body.	1) Physical relaxation	1) Alcohol, tranquilizers (e.g., Librium, Valium, some over-the-counter sedatives, etc.), cannabis (marihuana and hashish)
	2) Relief from pain or anticipated prevention of sickness	2) Physician prescribed drugs, over-the-counter (OTC) drugs
	3) Increased physical energy, avoidance of fatigue	3) Stimulants (e.g., amphetamines, cocaine)
B. Sensory: Pertaining to the enhancement, exaggeration, or intensification of the physical senses.	1) Intensification/enrichment of sensory input (e.g., sound, sight, touch, etc.)	1) Psychedelics (e.g., LSD, Mescaline, Psilocybin, STP, etc.), cannabis, occasionally others
	2) Enhancement of sexual experience	2) Alcohol, cannabis, occasionally others
C. Emotional: Pertaining to psychological and emotional experience, especially that which occurs within a personality; includes those internal feelings set off by the environment.	1) Psychological escape or release from emotional agony	1) Any, especially narcotics and alcohol
	2) Reduction of normal tension, anxiety, conflict	2) Alcohol, barbiturates, OTC sedatives, tranquilizers, cannabis
C. Emotional: **(Continued)**	3) Emotional relaxation	3) Alcohol, tranquilizers, cannabis
	4) Mood alteration	4) Stimulants, alcohol, cannabis
	5) Desire for psychological/emotional insight	5) Psychedelics, cannabis
	6) Avoidance of decision-making; pressure avoidance	6) Any
	7) Desire for privacy, aloneness	7) Alcohol, narcotics
	8) Rebellion; assertion of independence or defiance of authority	8) Any, especially illicit or forbidden substances
	9) Intensification of personal courage	9) Stimulants, alcohol
	10) Increase in self-esteem	10) Any, especially alcohol, stimulants and cannabis
D. Interpersonal: Pertaining to interpersonal relations, acceptance in groups, feelings of communication among individuals, opposite sex relationships, etc.	1) Gain in peer recognition, as in "showing off"	1) Any
	2) Gain in peer acceptance, as in behaving according to "peer pressure"	2) Any

TABLE ONE (Continued)

Level of Experience: Type of Gratification	Corresponding Motives, Needs, Aspirations	Most Probable Drugs of Abuse
D. Interpersonal: (Continued)	3) Relaxation of interpersonal inhibition; facilitation of social interaction	3) Any, especially alcohol and cannabis
	4) Reduction of anxiety-provoking intimacy	4) Narcotics, cannabis, etc.
	5) Reduction in barriers to communication; also solution of interpersonal problems	5) Psychedelics, cannabis, stimulants
	6) Escape/release from family difficulties	6) Any
	7) Escape/release from feelings of loneliness, alienation	7) Any
	8) Establishment of feeling of "community" or belonging with actual or reference group	8) Any
E. Mental-Intellectual: Pertaining to the experience of mental and intellectual processes, such as thoughts, ideas, problem-solving, etc.	1) Reduction of boredom	1) Any
	2) Curiosity	2) Any
	3) Enhancement of learning processes	3) Stimulants, sometimes psychedelics
	4) Problem-solving, especially technical	4) Stimulants, sometimes psychedelics
E. Mental-Intellectual: (Continued)	5) Research on oneself, one's cognitive processes	5) Psychedelics, cannabis
	6) Mental fatigue avoidance, as in studying	6) Stimulants
F. Creative-Aesthetic: Pertaining to artistic creativity, the performance or aesthetic appreciation or experience of creative works or artistic phenomena.	1) Increase in creative performance ability	1) Cannabis, stimulants, psychedelics
	2) Increase in enjoyment of artistic productions	2) Cannabis, alcohol, psychedelics
	3) Creation of subjective states of fantasy or imagination	3) Psychedelics, cannabis
G. Experiential: Pertaining to generalized personal experience of new, unusual or intensified states of experience or consciousness. Usually somewhat difficult to label.	1) Desire for "pure pleasure," "fun," recreation	1) Any
	2) Nonspecific changes in consciousness or awareness; e.g., any "high," intoxication for its own sake, desire for a change, any change, in experience	2) Any
	3) Unusual distortion of the sensorium, "freaky" perception and associated experience	3) Psychedelics, cannabis, sometimes stimulants or barbiturates

TABLE ONE (Continued)

Level of Experience: Type of Gratification	Corresponding Motives, Needs, Aspirations	Most Probable Drugs of Abuse
G. Experiential: (Continued)	4) Engagement—the need to be personally and totally involved in the moment, whatever the experience; counteracting apathy and ennui	4) Any, except perhaps tranquilizers
H. Stylistic: Pertaining to styles of behaviors and attitudes, especially cognitive styles, cultural styles and life-styles.	1) Need for identification through *imitation*, by youth of adults, by adults of youth, from media and subcultural "hero" figures; peer imitation	1) Any
	2) Automatic chemical reliance, — i.e., the culturally infused style of substance ingestion for any perceived deficiency	2) Any
	3) Desire for *immediacy* of achievement; impatience, intolerance of delay of gratification	3) Any; tranquilizers, volatile chemicals, OTC drugs less so
I. Social-Political: Pertaining to experiences generated by identification or involvement with social causes or political movements; also reaction to social and political inertia or change.	1) Identification with anti-establishment forces	1) Cannabis, psychedelics; sometimes any illicit substance
	2) Rebellion against disliked laws	2) Cannabis, etc.
	3) Overcoming discouragement or desperation with social-political future	3) Any
	4) Induced change in mass consciousness, sometimes by attempted disruption of "the system"	4) Psychedelics
J. Philosophical: (General and Personal) Pertaining to the experience of a guiding philosophy of life, an explanation of the universe; also personal identity, including goals, purpose, and values.	1) Search for purpose and meaning in life	1) Psychedelics, cannabis, others depending on peer group
	2) Organization of experience into a belief structure	2) Cannabis, psychedelics, stimulants
	3) Search for personal identity	3) Psychedelics, cannabis (directly); other drugs (indirectly)
	4) Creation or change in values and philosophical lifestyle	4) Any, especially cannabis and psychedelics

TABLE ONE (Continued)

Level of Experience: Type of Gratification	Corresponding Motives, Needs, Aspirations	Most Probable Drugs of Abuse
J. **Philosophical: (General and Personal) (Continued)**	5) Overcoming frustration from lack of meaningful vocation and work	5) Any
K. **Spiritual-Mystical:** Pertaining to experience with religious, spiritual or mystical characteristics, including intangible internal experiences with spiritual overtones or labeling.	1) Desire for intense spiritual experience, often labeled "higher levels of consciousness"	1) Psychedelics, cannabis
	2) Desire for specific mystical states, e.g., "enlightenment," communication with God, etc.	2) Psychedelics, cannabis
	3) Overcoming frustration with organized religion	3) Psychedelics, cannabis
	4) Augmentation of unorthodox spiritual methodology, e.g., yoga, meditation	4) Psychedelics, cannabis
L. **Miscellaneous:** Pertaining to combinations of above levels; factors difficult to categorize in one schema.	1) Need for risk-taking, danger	1) Any, especially more dangerous drugs
	2) Need for adventure, exploration	2) Any
	3) "Vacuum phenomenon," or "What else is there to do?"	3) Any
L. **Miscellaneous: (Continued)**	4) Economic profit	4) Any illicit substance
	5) Combination of motives, needs, aspirations—none of which individually would produce drug abuse, but does in a cluster	5) Any
	6) Need to react to extreme mental or physical discomfort; e.g., as in the maintenance of narcotic addiction, or in extreme psychological pain and/or confusion	6) Any

Most of the categories and motives listed in Table One reflect proximate causes of drug abuse. This focus may be the most practical in development of alternatives programs. However, we should note that some alternatives theorists emphasize broader socio-cultural influences. Some of the many socio-cultural factors which have been suggested to be linked with drug abuse are the following:

1) General social and political disruption (erosion of confidence in Government, confusion over social goals, ecological uncertainty, etc.);
2) Breakdown of the family unit (more broken homes, family mobility, parental absence from the home, etc.);
3) Influence of the media (especially the advertising of chemicals);
4) Economic imbalance (existence of poverty, ethno-racial economic discrimination, affluence leading to boredom, etc.);
5) Rigidity of educational institutions (maladaptive characteristics of public education, boredom in schools, etc.);
6) Rapid technologic change;
7) Proliferation of value and belief systems; fluidity in standards of morality; and
8) Increase in leisure time.

TABLE TWO

LEVELS OF EXPERIENCE AND EXAMPLES OF ALTERNATIVES TO DRUGS*

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*Reprinted with permission from Allen Y. Cohen, *Alternatives to Drug Abuse: Steps Toward Prevention*. Institute for Drug Abuse Education and Research, John F. Kennedy University, Martinez, Calif., 1971.

Table Two
Levels of Experience and Examples of Alternatives to Drugs

Level of Experience: Type of Gratification	Corresponding Motives, Needs, Aspirations	Alternative Example
A. **Physical:**	Physical relaxation Relief from pain or anticipated prevention of sickness Increased physical energy, avoidance of fatigue	1) Relaxation exercises; "hatha" (physical) yoga 2) Dance and movement training 3) Training in preventive medicine; positive health habits 4) Dietary and nutritional training and habits 5) Physical recreation: competitive athletics (especially for *fun*); individual physical conditioning (e.g., jogging, exercise); hiking, nature study, certain outdoor work, etc. 6) Gentle addiction withdrawal 7) Experience and training in the martial arts, e.g., aikido, karate, judo
B. **Sensory:**	Intensification/enrichment of sensory input (e.g., sound, sight, touch, etc.) Enhancement of sexual experience	1) Sensory awareness training (including increased awareness of body position, balance, coordination, small muscle control, learning to diminish or intensify sensory input) 2) Massage 3) Visual exploration of nature 4) Responsible sexuality (e.g., possible education in noncoital sexuality for adolescents)
C. **Emotional:**	Psychological escape or release from emotional agony Reduction of normal tension, anxiety, conflict Emotional relaxation Mood alteration Desire for psychological/emotional insight	1) Competent, emphatic individual counseling 2) Competent, empathic group psychotherapy 3) Special therapeutic techniques, e.g., psychodrama and role-playing (expertly conducted)

TABLE TWO (Continued)

Level of Experience: Type of Gratification	Corresponding Motives, Needs, Aspirations	Alternative Example
C. Emotional: (Continued)	Avoidance of decision-making; pressure avoidance Desire for privacy, aloneness Rebellion; assertion of independence or defiance of authority Intensification of personal courage Increase in self-esteem	4) Instruction in the psychology of personal development (e.g., in secondary schools) 5) Effective education (including techniques like values clarification, especially in primary grades) 6) Emotional awareness exercises, e.g., learning body language, honest, open self-awareness; psychological awareness workshops and seminars (especially for adults)
D. Interpersonal:	Gain in peer recognition, as in "showing off" Gain in peer acceptance, as in behaving according to "peer pressure" Relaxation of interpersonal inhibition; facilitation of social interaction Reduction of anxiety-provoking intimacy	1) Creation of alternate peer groups 2) Competently run, empathic experiences in peer and group process (including group discussion, sensitivity and encounter groups) 3) Competent, empathic group psychotherapy
D. Interpersonal: (Continued)	Reduction in barriers to communication; also solution of interpersonal problems Escape/release from family difficulties Escape/release from feelings of loneliness, alienation Establishment of feeling of "community" or belonging with actual or reference group	4) Various "experiences in being," including interpersonal workshops aimed at development of caring, personal responsibility, confidence, trust and respect for others 5) Psychodrama, role-playing and other special techniques (expertly conducted) 6) Competent, empathic individual counseling for interpersonal troubles 7) Goal-directed, positive group activities through organizations such as Scouts, 4-H, F.H.A., school clubs, church organizations, etc. 8) Social confidence training; instruction in social customs, "manners" of human interaction (especially for shy children) 9) Self-examination of relationships 10) Family life educati[illegible]nd training

TABLE TWO (Continued)

Level of Experience: Type of Gratification	Corresponding Motives, Needs, Aspirations	Alternative Example
D. Interpersonal: (Continued)		11) Family therapy, family counseling, parent education 12) Premarital and marital counseling/education 13) Temporary alternate families, alternate foster homes 14) Emotional "tutoring," e.g., big brothers and sisters helping younger people 15) Creation of community "rap centers"
E. Mental-Intellectual:	Reduction of boredom Curiosity Enhancement of learning processes Problem-solving, especially technical Research on oneself, one's cognitive processes Mental fatigue avoidance, as in studying	1) Mental/intellectual hobbies and games; e.g., puzzles, chess, etc. 2) Intellectual excitement through reading and discussion 3) Intellectual challenge through education, exploring frontiers of knowledge, stimulating curiosity 4) Introspection; analysis of thought
E. Mental-Intellectual: (Continued)		5) Memory training 6) Training in problem-solving and decision-making, e.g., "Synectics" training 7) Concentration and attention exercises 8) Training in mind control, e.g., "psycho-cybernetics," auto suggestion, positive thinking, etc.
F. Creative-Aesthetic:	Increase in creative performance ability Increase in enjoyment of artistic productions Creation of subjective states of fantasy or imagination	1) Non-graded instruction or experiential opportunity in appreciation of artistic productions, e.g., music, art, drama, etc. 2) Opportunities for artistic participation, e.g., non-graded lessons in art, music, drama, etc. 3) Creative hobbies (e.g., crafts, sewing, cooking, gardening, handiwork, photography, etc.)

TABLE TWO (Continued)

Level of Experience: Type of Gratification	Corresponding Motives, Needs, Aspirations	Alternative Example
F. Creative-Aesthetic: (Continued)		4) Experience in communication skills, e.g., writing, public speaking, media, conversation, etc. 5) Theater games; other procedures encouraging imagination and creative fantasy 6) Creation of community centers for the arts
G. Experiential:	Desire for "pure pleasure," "fun," recreation Nonspecific changes in consciousness or awareness; e.g., any "high," intoxication for its own sake, desire for a change, any change, in experience Unusual distortion of the sensorium, "freaky" perception and associated experience Engagement—the need to be personally and totally involved in the moment, whatever the experience; counteracting apathy and ennui	1) Self-generated play experience 2) Experiments in sensory deprivation 3) Bio-feedback training, e.g., alpha wave training 4) Sleeplessness & fasting (natural procedures for "intoxicated" states, only with health parameters) 5) "Mind-tripping," e.g., guided daydreams and fantasy 6) Hypnosis (expertly conducted)
H. Stylistic:	Need for identification through *imitation*, by youth of adults, by adults of youth, from media and subcultural "hero" figures; peer imitation Automatic chemical reliance,—i.e., the culturally infused style of substance ingestion for any perceived deficiency Desire for *immediacy* of achievement; impatience, intolerance of delay of gratification	1) Exposure to others deeply and meaningfully involved in non-chemical alternatives 2) Exposure to "hero" figures unfavorable to chemical abuse 3) Enlistment in anti-drug or alternative programs 4) Exposure to philosophy of enjoying the *process* of attainment, not just the *product* 5) Parental abstinence and moderation in drug use (parent agreement to cut down to give better example to children) 6) Exposure to philosophy of the "natural," education regarding the artificiality of chemical dependence
I. Social-Political:	Identification with anti-establishment forces Rebellion against disliked laws	1) Partisan political action, e.g., helping candidate campaigns

TABLE TWO (Continued)

Level of Experience: Type of Gratification	Corresponding Motives, Needs, Aspirations	Alternative Example
I. **Social-Political: (Continued)**	Overcoming discouragement or desperation with social-political future	2) Non-partisan lobbying, e.g., for ecological projects
	Induced change in mass consciousness, sometimes by attempted disruption of "the system"	3) Personal political involvement, e.g., running for elective or organizational office
		4) Field work with politicians and public officials
		5) Involvement in social service, including:
		a) Providing voluntary service to the poor (e.g., day care for working mothers, helping to locate housing, assisting access to health services, etc.)
		b) Providing companionship to the lonely, (e.g., companions for the aged, foster children, prison inmates, etc.)
		c) Work with schools (e.g., student tutoring programs, volunteer teaching assistants and counselors, etc.)
		d) Work with drug abuse problems (e.g., peer or volunteer counseling, information provision)
		e) Work in preserving environment (e.g., recycling, identifying pollution, preservation of areas of natural beauty)
		6) Participation in ACTION (e.g., VISTA and Peace Corps)
		7) Citizen "potency" training (i.e., learning effectiveness with Government and bureaucracy)
		8) Voluntary efforts through organizational sponsorship, e.g., YMCA. Boys Clubs. Big Brothers. etc
		9) Construction of responsible [illegible] in community organizations [illegible] government [illegible] [illegible]

TABLE TWO (Continued)

Level of Experience: Type of Gratification	Corresponding Motives, Needs, Aspirations	Alternative Example
J. Philosophical: (General and Personal)	Search for purpose and meaning in life Organization of experience into a belief structure Search for personal identity Creation or change in values and philosophical lifestyle Overcoming frustration from lack of meaningful vocation and work	1) Seminars, workshops on values and meaning of life (adults) 2) Courses on values, ethics, morality, meaning, etc. (schools) 3) Reading philosophical literature 4) Values clarification procedures; identity clarification procedures 5) Exposure to philosophical (non-violent) aspects of martial arts, e.g., aikido and karate 6) Exposure to metaphysical literature and thought 7) Humanistic counseling oriented toward meaning and values clarification 8) Achievement values, from meaningful challenge from career or employment 9) Exposure to individuals committed to varieties of personal philosophies 10) Creation of community "growth centers" 11) Maximization of ethnic, racial and minority pride
K. Spiritual-Mystical:	Desire for intense spiritual experience, often labeled "higher levels of consciousness" Desire for specific mystical states, e.g., "enlightenment," communication with God, etc. Overcoming frustration with organized religion Augmentation of unorthodox spiritual methodology, e.g., yoga, meditation Pertaining to the experience of a guiding philosophy of life, an explanation of the universe; also personal identity, including goals, purpose, and values	1) Study of spiritual literature; increased library holdings relevant to non-chemical spiritual methods 2) Creation of information centers for spiritual alternatives 3) Exposure to holy men of different belief systems; exposure to different techniques of applied spirituality 4) Meditation 5) Yoga (especially non-physical components) 6) Contemplation and prayer 7) Spiritual dance and song

TABLE TWO (Continued)

Level of Experience: Type of Gratification	Corresponding Motives, Needs, Aspirations	Alternative Example
K. Spiritual-Mystical: (Continued)		8) Increased course offerings in intellectual and experiential components of spiritual study (especially college level and secondary level)
L. Miscellaneous:	Need for risk-taking, danger	1) Sky-diving; scuba-diving, etc.
	Need for adventure, exploration	2) "Outward Bound" survival training
	"Vacuum phenomenon," or "What else is there to do?"	3) Exploration of new physical environments, e.g., flying, soaring, camping in wilderness areas, etc.
	Economic profit	
	Combination of motives, needs, aspirations—none of which individually would produce drug abuse, but does in a cluster	4) Competence of "self-reliance training," e.g., vocational and occupational education, instruction in household technology (i.e., autos, electronics, plumbing, household appliances, etc.)
	Need to react to extreme mental or physical discomfort; e.g., as in the maintenance of narcotic addiction, or in extreme psychological pain and/or confusion	5) Family management education, i.e., accident prevention, childcare, money management, first aid, menu and diet planning, etc.
L. Miscellaneous: (Continued)		6) Vocational counseling leading to meaningful employment
		7) Credited work experience through schools, e.g., house-building, merchandising, service station maintenance, restaurant training, etc.

MODULE IV

MODULE IV: KNOWING YOUR COMMUNITY **TIME:** 3 HOURS

GOALS

- Examine important factors in selecting prevention strategies
- Provide trainees with direction in identifying needs and resources within their own communities.

OBJECTIVES:

At the end of this module, participants will be able to:

- List at least five critical factors participants will consider in developing a drug abuse prevention program for their community
- List 4 major interest groups in their community
- Develop a profile of their community strengths, resources, and values.

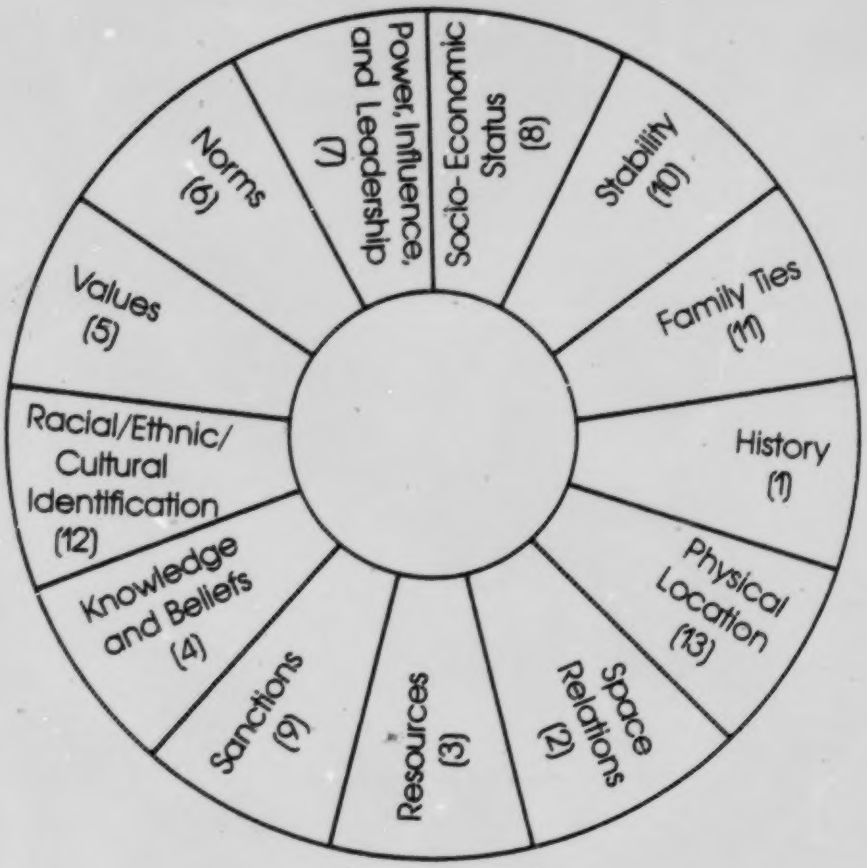
MATERIALS:

- Newsprint
- Pencils
- Magic Markers
- Worksheets
  - Social Compass
  - Community Functions

MODULE IV OVERVIEW

EXERCISE	TIME	METHODOLOGY
1. INTRODUCTION	5 MINUTES	LECTURE
2. ELEMENTS OF A COMMUNITY	1 HOUR, 5 MINUTES	LECTURE/DISCUSSION
3. WHAT GOES ON IN A COMMUNITY?	30 MINUTES	LECTURE/DISCUSSION
4. DEVELOPING A COMMUNITY PROFILE	45 MINUTES	INDIVIDUAL EXERCISE
5. REVIEW/PREVIEW	5 MINUTES	LECTURE

A Community Social Compass


History (1)
Space Relations (2)
Resources (3)
Knowledge and Beliefs (4)
Values (5)
Norms (6)
Power, Influence, and Leadership (7)
Socio-Economic Status (8)
Sanctions (9)
Stability (10)
Family Ties (11)
Racial/Ethnic/ Cultural Identification (12)
Physical Location (13)

LEGEND

1. History: History may be thought of as the "selective recording and interpretation of past elements." That is, you never learn about all of the previous activities in the life of a country or community; the causes and effects of past events are usually explained in one way or another.

   In reviewing the history of the community, we are concerned with:

   - Its official and more or less "objective" history as it may be given in public documents, etc.;
   - Its traditions or folk history as recounted by its residents.

   A preliminary study of the history of the community provides:

   - Background information needed to understand its present position and problems;
   - A widely acceptable means to show your respect for its people and their way of life;
   - An opportunity to meet a number of its key residents; and
   - Many insights into conflicting values, factions, etc.

2. Space relations: through this element we look at:

   - The internal relations within the community, its geographic area, and the disposition of its people, industry, social activities, etc.;
   - The external relations of the community with other communities in the vicinity and with the regional and national capitals, including the means of communication and transportation and the distances and time involved for each; and
   - The number and kinds of links that exist between this community and others through trade, marriage, etc.

3. Resources: The resources of a community are any aspects of its total environment which its people may use to meet their individual and shared needs. Such resources include the services available from government and private agencies. In assessing resources, the following subdivisions may be useful:

   - Human--the number of people and their capabilities, with allowances made for age, disease, malnutrition;
   - Man-made--such items as roads, communication media;
   - Natural--land, water, minerals, forests, sources of energy.

4. Knowledge and Beliefs: This element covers what is known and thought about the world, and life in it, and is thus related to technology, the use of resources, and goals.

   In belief there is an aspect of personal conviction which is absent from mere knowledge. It is therefore easier to change knowledge, on the whole, than to affect belief. On the other hand, a program linked to people's beliefs has a firmer foundation than one which is based upon items of information which they know, but do not particularly care about. Beliefs are linked with values and with sentiments.

5. Values: Values are essentially "ideals of the desirable" which are held by individuals; many values are shared by most of the people in the community and thus form the basis for predictable patterns of behavior.

6. Norms: Norms are the standards of what is right or wrong, good or bad, and appropriate or inappropriate in social life in the community. They form the "rules of the game" which indicate acceptable standards of conduct for every social situation. Norms are specific recommendations for behavior derived, like goals, from the values and sentiments of the people. Norms are enforced by various forms of social pressure in the community.

7. Power, Leadership, and Influence: Power describes the ability of one person to control others.

   The leadership positions in a community range from formally elected offices to the informal leadership. Leadership involves the ability to help a group make decisions and to act on them; it may include organizing people formally or informally. Remember that a leader is one who has followers--not all who act and sound like leaders actually have followers. Leadership capacity is indicated by the number and stability of a leader's following. Most leaders lead from in front; many other effective leaders prefer to lead from behind, quietly and almost unnoticed--don't overlook them!

   Influence is the ability to affect the behavior of others, often without their being fully aware of it.

   Note that while some people possess these capacities in most spheres of community life, others are effective in only one area; e.g., a woman may be a power figure, a leader or influential in matters of agriculture, but not in social or political life.

8. Socioeconomic Status: Social rank describes the standing that a person or group has in the community. It may depend largely on one's family and inherited characteristics, or it may rest upon the individual's personal achievements. The factors which determine who "rates" depend a good deal on the values which predominate in the pattern being considered.

9. Sanctions: These are the rewards and punishment which induce an individual to retain the goals and norms of the group. They help to assure the preservation of the group and its way of life by encouraging support for its values and sentiments, positions and roles.

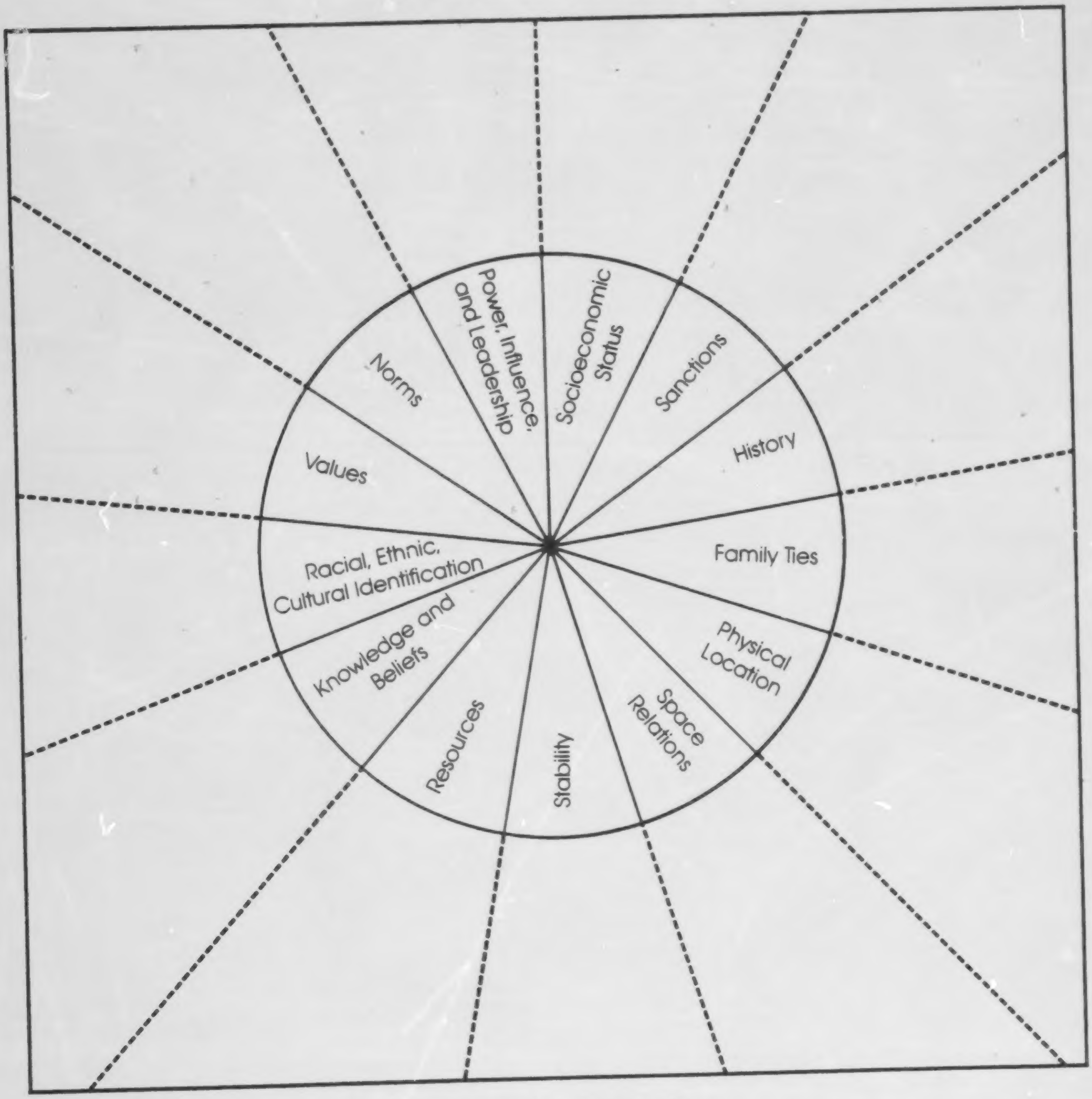
10. Stability: Stability is the degree to which a community remains constant in terms of its institutions, its members, and even its location. The stability of a community often determines the methods that must be used to address social problems. Many social problems are directly related to the lack of stability in a community.

11. Family Ties: The family ties that are common in any given community may range from the percentage of children without parents, to the frequency of extended family ties where three or even four generations live in the same household. The median is the standard two-parent family. Family intervention is one important means of addressing behavior problems in youth.

12. Racial/Ethnic/Cultural Identification: Many, if not most, communities are made up predominantly of one racial group. These racial groups vary in the degree of their identification with the cultural and historical past. For some communities, traditions actually form the base for that community and much of the other aspects of life are built around those traditions. Strict compliance with the traditions is a major factor for those groups. For other communities, the culture is scorned and looked down upon.

13. Physical Location: Physical location relates to the degree of isolation of a community. In many communities, isolation is a factor in determining many influential approaches to social problems. On one hand, isolated communities may not have a particular problem due to its isolation, but on the other hand, some problems that it does have can't be adequately addressed because of the lack of support services available to that community, due to its isolation.

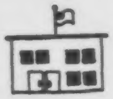
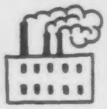
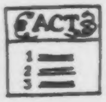
CMA Social Compass


Power, Influence, and Leadership
Socioeconomic Status
Sanctions
History
Family Ties
Physical Location
Space Relations
Stability
Resources
Knowledge and Beliefs
Racial, Ethnic, Cultural Identification
Values
Norms

Adapted from Conner, Desmond M.: Understanding Your Community. Ottawa: Development Press, 1969.

MODULE IV: KNOWING YOUR COMMUNITY--2 **WORKSHEET**

Community Functional Areas

HOME **1**	SCHOOL **2** 	CHURCH **3**
NEIGHBORHOOD **4**	HEALTH SERVICES **5**	SOCIAL SERVICES **6** VISITING NURSE
RECREATION AND LEISURE **7**	BUSINESS AND INDUSTRY **8** 	JUSTICE AND SAFETY **9**
LEGISLATURE **10** 	LOCAL GOVERNMENT **11**	MEDIA **12**

CONDUCTING A COMMUNITY ASSESSMENT*

Prepared By

William H. Wheeler, Ph.D.

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*Reprinted with permission from A Handbook Designed to Assist Counselors in counseling from a Cultural Perspective, developed under contract with the Florida Drug Abuse Prevention & Education Trust. Washington, D.C.: A.L. Nellum & Associates, Inc., September 1977.

CONDUCTING A COMMUNITY ASSESSMENT

NEEDS ASSESSMENT

In the Evaluation Theory section of this manual we presented the "Evaluation Cycle". That cycle is one model that can be used to guide most programs in the development of their evaluation strategies. We refer to the cycle at this time to focus our attention on its second component - CONDUCTING A NEEDS ASSESSMENT. This section of the manual will deal expressly with that topic. Much of the content covered is based on material adapted from:

1. Warheit, Bell and Schwab, "Planning for Change: Needs Assessment Approaches," 1974.
2. Hargreaves, Attkisson, Siegal, McIntyre and Sorensen, "Resource Materials for Community Mental Health Program Evaluation, Part II - Needs Assessment and Planning," 1974.
3. From the University of Denver, "Analysis and Synthesis of Needs Assessment Research in the Field of Human Services," 1974.
4. From recent research conducted by Don Cahalan and Associates in Analyzing our National Drinking Practices.

A Definition (Warheit, Bell and Schwab, 1974, p. 4)

"A needs assessment program is a research and planning activity designed to determine a community's.....health services, needs and utilization patterns."

(University of Denver 1974, p. 3)

A needs assessment also determines the extent and type of dysfunction that certain individuals or groups experience in a community.

Once determined, services can be developed to improve the level of functioning for those people.

When conducting an assessment, we must first develop a tool that will measure the problem and then use the information collected to provide needed services.

SOME USES OF A NEEDS ASSESSMENT
(International Encyclopedia of the Social Sciences, Gruenberg 1968, Morris 1957)

1. Knowledge regarding time-period comparisons or trends. This information helps to distinguish problem areas that are increasing from those that for the present time seem to be stabilizing, and finally those that are diminishing.

2. Community estimates of the size, location and distribution of conditions aid in planning programs for the community and in identifying possible points of intervention.

3. From accumulated records of the ages at which individuals contract a problem, individual risks can be estimated and high priority target populations for preventative or treatment services may be identified.

4. Knowledge of the attributes of cases not in treatment enlarges the clinical picture by making our concept of a disorder less dependent on the clinician's limited perspective on cases.

5. Occasionally, new problems may be identified.

6. The working of services can be studied in terms of their success and failure, their selection of cases for treatment and the effects on the people they seek to serve.

7. In the search for causes of disorders, data on the factors associated with the distribution of a disorder supplement laboratory and clinical data in clarifying the causes of (alcohol related problems).

(Warheit, et. al. 1974, p. 12)

8. Provides data for the development/modification of agency based programs...

9. Provides management information data for administrative purposes.

10. A "Penetration Rate" can be established:

$$= \frac{\text{Number of different clients identified by alcohol services}}{\text{Number of individuals assessed to need services}}$$

This measures adequacy of performance.

THE IMPETUS BEHIND NEEDS ASSESSMENTS RESEARCH
(University of Denver 1974, pp. 4-6)

1. Social planning and resource allocation should be responsive to the problems and needs of the population.
2. These needs should be ascertained through an objective process. (They should not be just a reflection of what service providers see as needs.)
3. Changing governmental and organizational policies and procedures are demanding assessments for further funding and support.

WHEN SHOULD YOU DO A NEEDS ASSESSMENT?
(Hargreaves, et.al., 1974 p. 11)

1. The most advantageous time...to undertake an assessment program is in the very early stages of program development. This assists in:
    a. defining goals
    b. developing a program plan
    c. selecting program activities
    d. evaluating these activities to see that proposed interventions correspond with the needs
2. Assessment should be considered when programs are thinking about modifying current programs or adding new services.
3. During times of rapid social change within a service area. For example, changes created by major population shifts, major economic changes or natural disasters.

STATE OF THE ART
(Hargreaves, et.al., 1974 p. 19)

1. Technology in the area of social service research is in the state of infancy.
2. Methodological difficulties:
    a. Lack of reliability of measuring instruments.
    b. Problems associated with data collection.
    c. Lack of uniformity in classification of health problems. For example, when is a person an "alcoholic"?

(Parker G. Marden, 1974, p. 2)

3. In a review of 1973 proposals that had been funded by N. N.I.A.A.A., Marden found that 43% of the 385 studied lacked any estimate of the number of problem drinkers and/or alcoholic persons. An additional 18% provided an estimate, but did not say what it was based upon. The remaining 38% listed a method which was generally a simple statement of a proportion of the population being alcoholic. (These figures are usually based on percents developed by Jellinek.) This review points to the reality that many estimations of needs in the field of alcohol abuse are mere hunches or guesses based upon experience or subjective analysis, or are gross estimates that tend to be impressions of local needs.

4. Hargreaves observes that while assessment data may be imperfect, it is better than no data at all.

PLANNING THE ASSESSMENT PROGRAM

(Warheit, et.al., 1974 pp. 16-18)

The first step to take after making a commitment to do a needs assessment is to appoint a steering committee. Its membership should consist of administrative, clinical, board and citizen representatives. This broad based participation increases the likelihood of a successful project.

Once the committee is formed, a project director should be named. That person will be responsible for supervising the entire project.

Once established, the steering committee and project director must first deal with tasks related to the *definition*, *conceptualization*, and *operationalization* of the objectives of the program. Regardless of the type of assessment project being considered, a series of questions needs to be asked. The following list is typical.

1. What do we want/need to know?
2. Why do we want to know it?
3. How will the information be used once it is obtained?
4. Where can we find the data necessary to answer our research questions?
5. How can we obtain this data?
6. What useful data sources already exist at the local, state and federal levels?

7. How can we most advantageously compile, analyze and present the data?

8. Should any other agencies in the community be involved in the program? Why? Why not? How?

9. What will the program cost?

10. How long will it take to complete?

11. Where can we find the financial and personnel resources necessary to conduct the program?

12. Which of the available needs assessment programs will be most efficient for our purposes?

13. What are the relative advantages and disadvantages of each of these programs?

14. How much assistance will be necessary from special consultants? Where can we find them?

15. What techniques and processes are available whereby the findings can be translated into programs designed to meet human needs?

In response to question number six, we have included a list of possible sources of secondary data (i.e. data that has already been collected and is on record somewhere).

BEFORE YOU SPEND YOUR OWN MONEY
(Hargreaves, et.al., 1974 pp. 12-15)

A local (alcohol) program should undertake a thorough preliminary search to identify information collection efforts and data analysis already completed in its community and their usefulness and availability to the local program. Using existing data can save time and money when compared to "starting from scratch."

Possible sources of information and assistance include:
(secondary data)

1. Federations of Social and/or Health Agencies

   These organizations may compile health indices such as various mortality rates or incidence and prevalence rates for a certain disease.

2. City Planning Departments

These departments have detailed information of data by census tracts as well as other descriptive information about communities. Some may also have population projection studies which may be useful for long-range program planning.

3. Health Departments

Health departments have disease surveillance units.

4. Mental Health Associations

They may help in locating appropriate indicators and identifying (alcohol program) practitioners in the area. They also have some sense of state and local mental health policies.

5. Comprehensive Health Planning Agencies

Under law, these agencies (according to Hargreaves) have been required to identify medically "underserved" populations.

6. Universities

Universities may be currently involved in relevant community studies. Sociology and political science departments should be of the most assistance. Staff may also be used as consultants. In addition, student help may be available.

7. Funding Agencies

They may serve as consultants and may have suggestions on the location and usefulness of specific indicators.

8. Clearing Houses

N.I.M.H. supports three clearing houses:

a. The National Clearing House for Mental Health Information
b. The National Clearing House for Drug Abuse Information
c. The National Clearing House for Alcohol Information

All of these provide free computer literature searches in their areas of specialization as well as a broad information dissemination program.

THE AGENCY OVERVIEW

In most instances, agencies interested in doing needs assessment studies will have been established for some time prior to the initiation of the project. With this in mind, the next step in the design strategy will be to gather information about the agency itself.

THE AGENCY ACTIVITIES CHECKLIST

(Adapted from Warheit, Bell and Schwab, 1974 pp. 22-23)

The following list can serve as a guide to those conducting the agency baseline study. It is not intended to be exhaustive but rather suggestive of the kinds of activities which are extremely helpful in preparation for the anticipated utilization of the needs assessment finding.

1. It will be necessary to summarize the formal objectives of the agency.
2. An outline of the legal mandates, regulations and community expectations which govern or strongly influence the agency's activities should be prepared.
3. A brief listing of the programs currently underway in the agency will need to be compiled.
4. A list of the program staff and a brief summary of their relationships to the services being provided should be prepared. A table of organization or PERT chart may be helpful here.
5. A brief review of the operating budget of the agency will need to be made. A listing of the sources of support and budget allocations for the various programs will also be helpful.
6. A list of the clients seen by the agency over the past year or two should be compiled. (A random sample from each of the major services may be adequate for the purposes of this review.) An analysis of the age, sex, race, ethnicity, income, geographic distribution and other sociodemographic characteristics of the clients is relevant and necessary.
7. A cataloging of the presenting problems and types of treatment or assistance provided the clients should be completed.
8. An enumeration of the various sources of referral to and from the agency should be prepared.

9. It will be helpful to summarize the relationships the agency has to other human service agencies in the community.

10. It is important to note any trends or changes in the agency's life which appear significant.

THE COMMUNITY OVERVIEW

Once the baseline study of the agency's goals, programs, client characteristics and community relationships has been completed, the next step in the process is to do a descriptive overview of the community served by the agency.

THE COMMUNITIES ACTIVITIES CHECKLIST

(Adapted from Warheit, Bell and Schwab, 1974 p. 25)

The following list can serve as a guide for those conducting the community baseline study. It is not exhaustive; neither is it inflexible. Consequently, some committees may want to add or delete specific activities.

1. The first step is to summarize the objectives of the study.

2. Next, it is necessary to identify the data sources available and note their format. (See list on page 156.)

3. The next step is to obtain the sociodemographic data needed, e.g., age, race, sex, ethnicity, income, education, occupation, etc.

4. After these data are collected they can be plotted on a map of the community.

5. It will be important to obtain data on other human service agencies in the community. The comprehensiveness of this list and the services provided will be determined by the objectives of the project.

6. The final step is to prepare a summary statement for use by the committee.

These processes and decisions must be completed before the data collection begins. Selecting the needs assessment approach is the next phase of the project.

NEEDS ASSESSMENT METHODOLOGIES AND DATA SOURCES

1. Secondary data analysis. (This includes the "social indicators approach" and estimation formulas.)
2. Community forums.
3. Workshops using the Delbecq Nominal Group Process.
4. The community impressions approach. (Encompasses "Key Informant" and "Convergent Analysis".)
5. The Delphi Technique.
6. Surveys of service recipients.
7. Interview with service providers. (Includes identification of existing resources and "rates under treatment".)
8. Surveys of community views on problems and services provided. (See Appendix R)
9. Prevalence and incidence studies.

These methods can be used alone, but should be used with at least one other means listed to gain reliability of data.

DEFINITIONS OF PRIMARY AND SECONDARY DATA COLLECTION

Primary Methods - Methods that seek information in its original form, i.e., information that has not been collected or stored previously.

Secondary Methods - Use information that has already been collected or data that has already been analyzed dealing with particular items of interest to a program.

Many of the techniques to be discussed will combine both types of data sources. There are advantages and disadvantages to each method:

PRIMARY TECHNIQUES

Advantages

1. Can provide the most current, reliable and valid information.
2. Can identify multi-problem individuals.

3. Can provide information on the extent to which individuals having problems utilize services.

4. Can identify new information not available in existing records.

Disadvantages

1. Surveys can be complicated and expensive.

2. Surveys require well trained personnel. They should be knowledgeable in:

    a. Constructing valid instruments
    b. Sampling techniques
    c. Training interviewers
    d. Data analysis

3. Training issues:

    a. Interviews are costly and time consuming
    b. While volunteers could be used, they may create scheduling, training and coordination problems.

4. If you use mailed questionnaires, they are subject to:

    a. Low response rate
    b. Inaccurate and incomplete reporting

5. It is often difficult to distinguish between needs, desires, wants and demands of respondents.

6. Questions to consider before doing a survey:

    a. Data collection costs?
    b. Data availability?
    c. Potential accuracy?
    d. Potential usefulness?

SECONDARY TECHNIQUES

Advantages

1. Are usually quick and inexpensive.

2. Require fewer resources for collection than primary techniques (i.e. staff time and travel).

3. In-house staff can gather the data without additional training.

Disadvantages

1. Data may not be stored in the form an agency wishes to retrieve it.
2. The data may be inaccurate, incomplete and outdated.
3. Access to the data may be hindered by confidentiality restrictions.

SECONDARY DATA ANALYSIS

(The Social Indicators Approach, Warheit, et.al., 1974, pp. 47-61)

The social indicators approach is based primarily on inferences of need drawn generally from descriptive statistics found in public records and reports. The underlying assumption of the approach is that it is possible to make useful estimates of needs and social well-being of those in the community by analyzing statistics on selected factors which have been found to be highly correlated with persons in need. Some commonly used indicators:

1. Special arrangements of the community's people and institutions;
2. Sociodemographic characteristics of the population such as age, sex, race, income;
3. The social behavior and well-being of people, particularly as it relates to crime, substance abuse, family patterns and morbidity and mortality rates;
4. The general social condition within which people live, e.g., substandard housing, overcrowding, accessibility to services and economic conditions.

Data needed for alcoholism agencies may include:

1. Population characteristics
2. Mortality and morbidity rates
3. Crime patterns and arrest records

Most studies of this type use existing area units such as census tracts or block groupings. (See pages 162-163 for technique used to identify high risk census tracks.)

MENTAL HEALTH NEEDS INDICATORS:

RANK ORDER BY CENSUS TRACT CITY OF SUPERIOR AND BALANCE OF DOUGLAS COUNTY

CENSUS TRACT	0201	0202	0203	0204	0205	0206	0207	0208	0209	0210	0301	0302	0303
VARIABLE	RANK												
1. Female head of household	1	3	2	11	6	4	7	10	5	8	9	10	9
2. Isolation	3	2	5	10	7	4	12	11	6	9	1	13	8
3. Crowding	1	11	6	7	13	12	2	5	4	3	9	10	8
4. Per cent of males	5	1	12	10	7	11	9	8	13	6	4	3	2
5. Per cent of females	9	13	2	4	7	3	3	5	6	2	8	10	12
6. Per cent of people under 5	1	10	7	8	9	6	4	4	5	2	3	2	8
7. Per cent of people over 65	6	1	3	8	11	4	9	12	5	10	7	13	2
8. Per cent divorced	2	1	3	11	11	4	8	10	6	7	9	7	5
9. Fertility rate	1	11	4	13	12	10	6	7	5	8	3	9	2
10. Per cent in group quarters	1	10	3	6	1	9	8	5	7	10	4	2	7
11. Transience	3	1	8	12	2	4	11	5	7	11	10	9	6
12. Per cent families below poverty level	2	1	3	13	12	6	11	9	8	10	5	7	4
13. Per cent males over 16 not in labor force	1	2	4	10	11	9	5	12	3	13	6	7	8

CENSUS TRACT	0201	0202	0203	0204	0205	0206	0207	0208	0209	0210	0301	0302	0303
VARIABLE	RANK												
14. Per cent non-owner occupied housing	2	1	4	12	5	3	6	11	8	7	9	10	13
15. Per cent males not in professional, technical or kindred occupations	8	1	11	12	13	9	10	4	7	2	6	5	3
16. Per cent service workers	1	2	3	12	9	4	7	6	8	10	6	5	13
17. Per cent unemployed	1	2	6	9	8	7	6	11	5	10	7	4	3
18. Per cent families receiving public assistance	2	1	5	7	11	7	10	12	9	4	3	8	6
19. Per cent families below poverty level with female head	2	1	4	12	11	3	7	9	8	10	6	4	5
TOTALS	52*	75	95	187									

* Represents the highest risk census track (high probability of social disorder).

Common sources of data:

1. Reports provided by the U.S. Bureau of Census
2. Reports of national, regional, state and local health, education and welfare agencies
3. Crime statistics
4. Court records
5. Bureaus of vital statistics
6. Health planning councils
7. Also see page

Advantages

1. The data is already collected.
2. Data can be secured at low cost by persons with a limited amount of research training.
3. The data is flexible, i.e., it can be compared to other communities. Also, data can be derived from several sources to be used in a single index of need.
4. Data can be used for future needs assessments.

Disadvantages

1. Some of the indicators may not be valid measures of need or problem areas.
2. Analyzing social indicators may require sophisticated, computer-based, statistical techniques.

ESTIMATION FORMULAS

The use of estimation formulas is one popular approach used to determine the number of alcoholics and/or problem drinkers in a given population. These formulas rely on data from mortality and morbidity rates and on data from citizen surveys.

We will present five methods:

1. Schmit and deLint (1970), uses data on the number of deaths attributable to cirrhosis of the liver.

   $A = \frac{PcDc}{Rc} \times 10,000$

   A = Number of alcoholics
   Dc = Number of cirrhosis deaths
   Pc = Percent of cirrhosis deaths attributable to alcoholism (.37)
   Rc = Death rate due to cirrhosis per 10,000 alcoholics (16.5)

2. Schmit and deLint (1970), also uses data on suicides in a given year.

   $A = \frac{DsPs}{Rs} \times 10,000$

   A = Number of alcoholics
   Ds = Number of suicides in a year
   Ps = Proportion of alcoholics among suicides (.25)
   Rs = Death rate due to suicide per 10,000 alcoholics (12.39)

3. The Parker G. Marden formula is based on national surveys conducted by Cahalan, Cisin, Crissley and Room. (See appendix P)

4. A comparison of a local geographic region to the nation.

   $$\frac{X}{\text{1970 Geographic Region Total Population}} = \frac{\text{9 million (a 1970 estimate) alcoholics}}{\text{1970 United States population}}$$

   X = Number of alcoholics in your geographic region.

5. This method is based on work done by Keller (1975). He estimated that 5.2% of all drinkers (age 15+) are alcoholic and another 5.2% are pre-alcoholic.

   Problem drinkers = Percent of drinking population 15 and over X 10.4%
   = .70 (Population 15+) X .104

   Based on national data, it is estimated that 70% of the people 15 and over drink. (Alcohol & Health, 1971)

Methods 1, 2 and 4 measure "alcoholics" and should be multiplied by two to include "problem drinkers." This suggestion is based on research reported by Keller in 1975. He estimated that for every alcoholic there is another pre-alcoholic person whose drinking is causing problems for him/her. (Keller, 1975, p. 1446)

COMMUNITY FORUMS

(Hargreaves, 1974, pp. 64-77)

Any person living or working in a community is likely to have consciously or unconsciously developed some idea about the drug service needs of that community.

Each person associated with a community is "an expert" on some of the sociological and psychological aspects of that community.

Although no two people may have the same view, by pulling these views together one starts to develop a viable picture of the drug service needs in a community.

A *community forum* is one way to tap these views.

Definition:

A community forum is an open meeting for all members of a designated community. Its purpose is to give all members of the community an opportunity to air their views on or feelings about a particular issue -- in this case alcohol problems.

Advantages

1. Quick and cheap
    a. Planning done in a few weeks
    b. Meeting takes a few hours
    c. Costs include:
        1. Time of staff in planning, implementing and analyzing the forum
        2. Renting the hall
        3. Recording secretary
        4. Necessary transportation
        5. Child care services
2. Forum organizers can identify those most interested in doing something about unmet needs.

Disadvantages

1. Even with a good turnout, not everyone will have a chance to speak, so relevant input is lost.
2. Not all members of the community will attend, so results are not conclusive.

3. Discussion does not normally go beyond problem identification, so causes are not dealt with.

4. A forum may falsely raise expectations. If outcomes are unrealistic, results may be poor thus resulting in "we've been studied and questioned to death and nothing ever happens."

A forum is good for getting impressions and feelings, but not good for collecting facts and figures.

Points to Remember to Improve Forums:

1. Get diverse representation to make results more credible.

2. Wide publicity and inducement of groups to assure their attendance.

    a. Use more than one media.
    b. Make statements clear and simple and include: place, date, time, purpose, organizers and leaders.
    c. Publicize some several weeks before forum and more extensively one week and one day before.

3. Consult with knowledgeable community people for best place and time to hold the meeting.

4. Have a community member chair the meeting.

5. Limit speaking time to 3 minutes to avoid those who will dominate or those who speak on unrelated subjects.

6. Follow-up on the forum

    a. Prepare a list of attenders and thank them via mail.
    b. Tell them the immediate outcomes of the forum.
    c. Identify people who will work.

THE NOMINAL GROUP APPROACH DELBECQ TECHNIQUE
(Delbecq & Von de Ven, 1971)

This is a group workshop technique designed to increase the creativity and effectiveness of group idea generation.

The Process:

1. Pose a question or several questions to a group and then have each member of the group write down his/her answers during a silent period (10-15 minutes).
    a. The question may ask for possible solutions to a problem or ideas about a situation.
    b. Identify needs for service.

2. All ideas are shared with the group.

3. Each participant offers an idea from his/her list; these ideas are listed on newsprint and when ideas are exhausted the print is hung up on walls for all to see. *No comments or discussion at this time.

4. After round robin discussion is opened to define ideas, add new ones, eliminate some, or combine similar ones. (Ideas are read one at a time and discussion is asked for.)

5. The group chooses those ideas considered most important. Each person ranks 5 or 10 ideas they think important, the "votes" are tallied and a final list is arrived at.

6. There are five phases to this process:
    a. Problem Exploration
    b. Knowledge Exploration (deals with solutions)
    c. Priority Development (determined by administrators and resource controllers)
    d. Program Development
    e. Program Evaluation

    The Nominal group process is used at each phase.

Advantages

1. Avoids the following pitfalls of interacting (forum) group which are:
    a. The interacting group does not call for an abundance of new ideas.

   - b. Certain personalities tend to dominate, i.e. those in leadership positions or of high status.
   - c. Energy is wasted competing for the floor rather than listening to ideas of others.
   - d. Minority views are not heard.
   - e. New and innovative ideas tend to be discouraged.
   - f. Conversation falls in ruts and often disgresses from the main point.
   - g. Time is wasted and in the end, decisions are made hastily.

2. The silent period allows thinking time to produce ideas.

3. All group members participate.

4. Encourages minority ideas.

5. Avoids hidden agendas.

6. Everyone has to contribute.

7. Facilitates creativity.

8. Allows for airing personal concerns.

9. Does not allow any one person to dominate.

Disadvantages

1. Lack of some precision:

   Votes or rankings are made without thorough or careful sorting out of all the ideas generated into appropriate categories.

2. Some participants may feel manipulated in such a highly structured process.

COMMUNITY IMPRESSIONS APPROACH
(Encompasses "Key Informant" and "Convergent Analysis")

This is a method of collecting and combining existing data which gives clues about service needs with impressions about such needs from key individuals living or working in the community and then verifying the information gathered with those groups in the community identified as having the greatest needs.

Three major steps:

1. Once the community under study has been identified, interviews are conducted with ten or fifteen individuals who either work or live in the community. Individuals are selected on the basis of the longevity of their involvement with the community and/or the nature of their involvement with the community. Thus, a public health nurse, members of community action agencies, long time residents, a policeman or fireman, the local health officer and others are interviewed in order to elicit their impressions.

   The interviews are conducted with the aid of a list of questions about the existing alcohol services in the community and certain demographic characteristics of the population and *with a map* of the community under study. Answers to these questions are recorded on the map to provide a picture of the community from a service and demographic point of view. With the completion of the interviews, the impressions are collapsed into one map. Any discrepancies are erred in favor of a group having unmet needs (i.e. if one interview identified a group as having many alcohol related problems, and another interview identified that same group as having few, the group should be recorded at this time as having many -- this will be verified with the group under question at a later date).

2. Existing data which may provide clues about the mental health needs in the community are collected.

   Once this is collected, this "hard data" should be added to the map of impressions from the interviews.

3. A community forum is planned and held for each group or section of the community identified as having significant unmet mental health needs.

The Purpose

1. Validates identified needs.
2. Explores the nature and cause of those needs.
3. Involves those in need in the process of reducing need.

Advantages

1. The approach is inexpensive in terms of time and resources.
2. Combines both factual and impressionistic clues about service needs.

3. Those identified as having unmet needs actually have a chance to voice their views.

Disadvantages

The approach can be question in terms of reliability and validity. There is no way to insure that every group with service needs will be identified, nor that all the needs of those identified will have been recorded.

THE DELPHI TECHNIQUE
(See Appendix O)

Definition

"...a carefully designed program of sequential individual interrogations (best conducted by questionnaires) interspersed with information and opinions feedback..."

The Process

Typically the Delphi uses four questionnaires.

1. The respondents provide some input into the topic under discussion.
2. Respondents are asked to rate items on the first round.
3. Based on averages from the second round the respondent is asked to move toward group judgement or state the reason why he/she refuses.
4. The final questionnaire provides new consensus data, a summary of the minority opinions and requests for final revision.

Advantages

1. Delphi collects and organizes judgements in a systematic fashion.
2. It solicits a wide range of input.
3. It establishes priorities.
4. It builds consensus.
5. It organizes dissent.

6. It allows anonymity of responses which may encourage creativity.

Disadvantages

1. It is based primarily on subjective impressions and should be supplemented with objective data.
2. Questionnaire construction is difficult in terms of validity and reliability.
3. The pull toward consensus may sacrifice accuracy.
4. The process may be too time consuming.

SURVEYS OF SERVICE RECIPIENTS
(University of Denver, 1974 p.23)

Definition

A service population survey differs from a general population survey in that it seeks data only from individuals who are, or have been, in the service system.

1. It provides a picture of the service population and their problems.
2. It provides a first hand account of the barriers to service.
3. It provides a measure of program effectiveness through recipient satisfaction questions.
4. It can identify the type of service desired but not available.

Problems

The data collected can not be generalized. The problems or needs of the nonservice population may be different from the service population.

SURVEYS OF ALCOHOL AGENCIES AND SERVICE PROVIDERS
(University of Denver, 1970, pp.24-25)

Definitions

This type of survey analyzes the patterns of service utilization and the impressions of administrators and practitioners as to high priority problem areas.

1. Needs are identified by demands for service.
2. Data is provided on service needs not widely recognized or socially acceptable.
3. Service providers are a valid source of information on existing community resources.

Problems

1. Agencies may not be providing services to the highest risk population.
2. Problems identified by service providers may reflect cultural or class biases.
3. Practitioners may be most experienced with and therefore have a vested interest in the services they provide.
4. Under-utilization may not reflect low priority, but instead may be a product of poor publicity and/or temporal or cultural barriers.

The following areas are of particular interest to a survey of agencies and service providers: (Hargreaves, 1974, p.52)

1. Referrals (demand)
   a. number
   b. source
   c. reasons (symptoms, problem areas)
   d. other characteristics
2. Accepted for service
   a. number
   b. diagnosis
   c. socio-demographic characteristics of clients -- who is refused service and reasons for refusal
3. Waiting list
   a. number
   b. source
   c. reasons (symptoms)
   d. other characteristics -- average time on waiting list
4. Service provided
   a. desirable services -- that organization would like to provide

b. actual services given

5. Referrals out of the agency

INFORMATION ON AVAILABLE RESOURCES
(Hargreaves, 1974, pp.53-54)

1. Range of services provided.
2. Client entry policies: conditions of eligibility for service; including available demographic descriptions such as age, sex, financial criteria, geographic restrictions and particular target population.
3. Staff characteristics: who provides services, their training, treatment modalities used, number of staff, average client load per staff member.
4. Financial characteristic:
   a. charge for services -- fee schedule, eligible for third part reimbursement, sliding scale provision
   b. agency support -- public or private, fees as percentage of total support
5. Accessibility:
   a. location of facility
      - convenient to target populations
      - convenient to public transporation
   b. referral procedure
      - is it cumbersome
      - well publicized
      - hours open for service
      - comfort, acceptability of facility
      - provision for child care when appropriate
6. Program inter-relationship

STANLEY ROBIN'S PROCEDURE FOR INCREASING RETURNS FROM MAILED QUESTIONNAIRES FROM AGENCIES

(Hargreaves, 1974, p.92)

Two of five contacts with the potential respondent

1. The first contact is a pre-questionnaire letter sent to the respondents containing the following elements:
    a. Request for the individual to participate in the research
    b. Its importance and possible applications
    c. Information that he/she will shortly receive a questionnaire
    d. Assurance of anonymity and confidential handling of information

    When possible, write the letter on a letterhead, co-signed by someone representing legitimate authority and validating the importance of the research and the appropriateness of the subject's participation.

2. A cover letter and the questionnaire.

3. Follow-up, strategies, i.e. telephone calls, reminders, thank you's, etc.

Examples of questions to ask:

1. Kinds of alcohol problems encountered?

2. Number of clients (estimate) with drinking problems?

3. Demographic characteristics of clients?

4. How do they handle problems? i.e. Do they refer? If so, where?

5. What problems do they have in making referrals?
    a. transportation
    b. financial
    c. temporal and cultural barriers
    d. unacceptable treatment staff
    e. poorly motivated clients
    f. lack of appropriate service

6. Type of alcohol service that would be most helpful.

7. Feedback results in the thank you note.

More specific questions can be asked within each category.

SURVEYS OF COMMUNITY VIEWS ON PROBLEMS AND SERVICES PROVIDED

Many programs either ignore community views or consider advisory boards adequate. These boards are often little more than window dressing or rubber stamps and only react to planning decisions already made. Also, membership on these boards may not reflect the needs of the entire community.

This type of survey would include a random sample of people living within a geographically defined service area. The sample could be stratified by census tracts, race, age or economic status. It may cover certain high risk groups such as the 20 to 24 year olds or those living in the lower socioeconomic areas.

Examples of information asked for: (Hargreaves, 1974, pp.57-58)

1. General community problems viewed as most important.
2. Sources for help for particular problems.
3. Problems thought most important.
4. Attitudes toward alcohol programs.
5. Alcohol programs thought most important.
6. Alcohol problems experienced in their own families.
7. Was help received for these problems? If not, why?
8. What services have been received and an indication of satisfaction?

Advantages

1. Surveys of the community provide information available through no other source.
2. Data is based on service as well as non service population.
3. When well constructed instruments are used, this approach provides the most valid and reliable data available.

Disadvantages

1. The technique is usually more expensive and time consuming then others.
2. Some individuals are reluctant to supply information about themselves or other family members.
3. A high refusal or non return rate may invalidate the results.
4. Questionnaire construction may be fraught with validity and reliability problems.

Specific advantages and disadvantages of mail, telephone and personal interviews are discussed in the follow-up section of this manual, pages 224-8.

(For an easy to read explanation of basic sampling techniques, see Warheit, et.al., 1974, pp. 78-113)

ACTIVITIES CHECKLIST TO DEVELOP A STEP-BY-STEP NEEDS ASSESSMENT
(Warheit, 1974, pp.77-78)

1. The committee will need to begin by describing carefully the overall objectives of the study. On the basis of these objectives it will develop the concepts appropriate to the inquiry and operationalize these goals and concepts by preparing a design-methods outline to guide them throughout each stage of the process. As a part of this process, the committee will want to examine closely the questions on page 155, which are designed to assist those engaged in planning of the assessment program. The committee will also want to study the chapters detailing methods and procedures. Many very important items are included in this section and their careful consideration will be useful in helping to decide which survey can be used most effectively and how it can be conducted.
2. The population to be studied needs to be "identified" and an appropriate sample prepared.
3. The items for the questionnaire/schedule will need to be decided upon; their format and design will also need to be determined in the light of the objectives of the study, the unit for analysis and anticipated methods of analysis and presentation.
4. Interviewers will need to be recruited and trained or, in the case of a mailed questionnaire, letters will need to be prepared for mailing.

5. An extensive program of publicity should be commenced just prior to the initiation of the survey.

6. Appropriate agencies in the community which can "legitimate" the study should be contacted and appraised of the program. It is often important to inform law enforcement agencies, chambers of commerce, medical societies and other community groups that a survey is being conducted since they are sometimes called by citizens who have been selected as respondents/informants in the survey.

7. A system for coding, punching and analyzing the data will need to be decided upon and put into effect during the survey.

8. Once the data are gathered, they must be analyzed for presentation.

9. The findings need to be presented along with a list of recommendations for action. These recommendations are more effective when they are listed in a rank order based on their priority. A time-cost estimate should accompany the list of recommendations.

PREVALENCE AND INCIDENCE STUDIES

Definition

This is a study that seeks to identify rates or levels of certain disorders by means of a general population survey.

Prevalence is the number of cases present at one point in time in a defined population, divided by the number of persons in that population at that point in time.

Incidence is the number of new cases arising during a unit of time in a defined population, divided by the number of persons in that population at that point in time.

This technique has all the advantages of other primary approaches (see page 159). The disadvantages, however, should be emphasized again.

1. Such studies are extremely complicated and costly.

2. They require extensive research and statistical knowledge.

3. Basic definitions are not yet established. For example, who is a problem drinker and who is an alcoholic?

EXTENT AND PATTERNS OF USE AND ABUSE OF ALCOHOL
(Don Cahalan and Associates, 1964, 1967, 1969, 1975)

Given their caveats, we will not be emphasizing the survey type of needs assessment technique in this workshop. We will, however, review the most complete study of its kind that has been done to date on the subject of the extent and patterns of use and abuse of alcohol. That research was carried out by the social research group of the George Washington University. The final analysis of these surveys are now being completed at the School of Public Health, the University of California, Berkeley.

Findings published to date are drawn from three surveys. (*Alcohol and Health*, HEW, 1971, Chapter 2)

Survey I

A 1964 - 1965 study, published in "American Drinking Practices", measured drinking practices and attitudes among 2,746 persons representing the adult household population (age 21+) of the contiguous United States

Two additional surveys measured and anlyzed the prevalence of various types of alcohol related problems among adults:

Survey II

A 1967 follow-up of the first survey studied a subsample of 1,359 adult men and women (age 21+). Reported in "Problem Drinkers" 1970.

Survey III

A 1969 survey studied a subsample of men age 21 to 59. Reported in "Problem Drinking Among American Men", 1974.

This research is *not* directed toward detection of the characteristics of those who may be suffering from the "disease" of alcoholism.

Problem drinking is defined as the repetitive use of beverage alcohol causing physical, psychological or social harm to the drinker and others. (Plaut, 1967, pp. 37-38)

There are three principle objectives:

1. To study the range of drinking practices as they exist in the whole society.

2. To analyze many correlates of drinking behavior such as demographic variables, personality characteristics and attitudes and to carry out short term measures of change in drinking behavior.
3. To lay the groundwork and to serve as a baseline for future studies of a longitudinal nature, in which the same individuals are being followed-up over a period of years in order to measure changes in their drinking over time.

Survey IV

Begun in 1975 and scheduled for completion in 1978. This survey will be a subsample of the previous surveys and is intended to measure any changes in drinking over time.

SAMPLE DESIGN
(Cahalan, 1969, pp.225-228)

The sample was designed to give each person 21 years or older, living in a household within the United States (exclusive of Alaska and Hawaii), an equal representation in the final results. The sampling procedures conformed to established principles of probability sampling at all stages of the process; in the selection of the areas for interviewing, the selection of households and the selection of individuals to be interviewed within each selected household.

The entire contiguous United States was divided and subdivided into areas equivalent to census enumeration districts. From these subareas, households were randomly selected to be included in the survey. Then one person over 21 was selected from each household. In the first survey (1964-1965) 2,746 were interviewed. In the second survey (1967) 1,359 were reinterviewed. In the 1969 survey a total sample of 1,561 (men age 21-59 only) were interviewed.

DATA COLLECTION

1. All interviewers were personally trained and supervised. They were non-abstainers and except in a few instances they were all men.
2. Interviews were completed at a rate close to 90% by using repeated visits, letters and telephone calls.

3. All interviewers had detailed instructions and each completed interview was rechecked for any errors.

NATIONAL SURVEY I (1964-1965)

There were 2,746 interviews completed all over the United States. The questionnaire (see Appendix Q) was designed to cover eight major categories:

1. Estimates of the amount of drinking within various subgroups (e.g., sex, age, socioeconomic status, region, size of town, race, national origin, religion);
2. Drinking of specific beverages: wine, beer or spirits;
3. Circumstances related to drinking: usual recreational activities, places where people drink and weekend as opposed to weekday drinking;
4. Retrospective reports of changes in amount of drinking: when respondent started to drink; whether he ever drank more or less than at present, and for what presumed reasons;
5. Drinking effects and problems: self-perception of one's own drinking; effects of drinking experienced during the previous year; whether others had tried to get respondent to drink more or less during the previous year;
6. Opinions about drinking: good and bad things that can be said about drinking; acquaintance with drinkers believed to have problems;
7. Correlation of personality attributes with drinking behavior, including analysis of such attributes as the respondent's general outlook on his own fortunes and values, activities he may have engaged in to relieve depression or nervousness, scores on seven brief personality scales (e.g., neuroticism, alienation, religious fundamentalism);
8. Characteristics of persons who drink to escape from personal problems, in comparison to others who drink only for presumably social reasons.

Based upon answers to questions on the survey schedule, respondents were given a problem score. There were eleven problem areas covered.

In general, Cahalan, et.al. categorized drinking-related problems into three broad areas:

1. The amount, patterning and style of drinking behavior.

2. The psychological loading of the respondent attaches to the behavior.

3. The physiological and social consequences of the behavior.

The specific areas measured:

1. Drinking behavior:

    a. heavy intake (frequent intoxication)
    b. binge drinking
    c. symptomatic drinking

2. Psychological involvement:

    a. psychological dependence on drinking or
    b. loss of control over drinking

3. Consequences of drinking:

    a. belligerence after drinking
    b. problems with spouse or relatives
    c. friend and neighbor problems
    d. job problems
    e. problems with police, law or accidents
    f. health problems and injuries
    g. financial problems

Three views of alcoholism:

1. Vice - emphasizes the drinking behavior

2. Disease - emphasizes the condition of the individual drinkers

3. Social problems - emphasizes the individual's relation with his/her social and cultural environment

(See Appendix P, pages 31-32 for the definitions of these problems.)

THE PROBLEM SCORE

A person is considered a "problem drinker" if he/she scores 7 or more points from the list of 11 problem areas.

6 points = a severe problem

3 points = a moderate problem

1 point = a mild problem

The score of 7+ is equivalent to:

1. Having problems in two or more areas with at least one problem scored as "severe".
2. Having problems in three or more areas with at least two problems "moderate" or more severe.
3. Having problems in five or more areas with at least one problem "moderate" or more severe.
4. Have at least slight problems in seven or more areas.

Respondents were also classified into an "Index of Social Position". A variant of the Hollingshead Index of Social Position was used in this survey as the principal index of socio-economic status... The index (ISP) takes into account the respondent's education, the occupation of the family breadwinner, and the status or power position associated with the occupation.

Another issue was one of measuring alcoholic beverage consumption and classifying people according to the amount they drink.

The national survey built upon the earlier types of quantity-frequency analysis and upon an expanded system, first used in the California study by Knupfer, based on 12 questions that took into account the quantity of alcohol per occasion, the frequency or number of occasions, and the variability or fluctuations in time and amount, as follows: The quantity of a beverage consumed at a sitting (this was measured separately for wine, beer and spirits by asking how often the person had as many as five or six, or three or four, or one or two drinks); the frequency with which each of the three types of beverage was usually drunk; the variability of drinking, as shown by a combination of the modal (most usual) amount consumed and the highest amount drunk at least occasionally. Thus, the drinking index used in the national survey might be called, instead of a Q-F index, a Q-F-V index (for quantity, frequency and variability).

The method used in making these three types of measurement was as follows:

Respondents were first handed a small, four-page, multicolored booklet as the interviewer made the statement, "The next few questions ask you about your own use of various types of drinks. Will you please take this booklet and on the first page put a check mark next to the answer that tells how often you usually have wine...Now please turn to the green page and do the same for beer... Now please turn to the pink page and do the same for drinks containing whiskey or liquor, including scotch, bourbon, gin, vodka, rum, etc....And now turn to the yellow page and please check how often you have any kind of drink containing alcohol, whether it is wine, beer, whiskey or any other drink."

On the booklet, wine was further defined as "(or a punch containing wine)"; and drinks containing whiskey or liquor were further defined as "(such as martinis, manhattans, highballs, or straight drinks)."

The frequency scale for each beverage, printed in the booklet to be checked by respondents, was as follows: "Three or more times a day; Two times a day; Once a day; Nearly every day; Three or four times a week; Once or twice a week; Two or three times a month; About once a month; Less than once a month but at least once a year; Less than once a year; I have never had wine (beer, drinks containing whiskey or liquor, any kind of beverage containing alcohol)."

The rationale for a scale so heavily loaded with responses indicating very frequent drinking was to give the respondent the impression that no matter how frequently s/he drank, there must be many others who drank even more frequently than s/he -- thus possibly reducing any reluctance to check a category indicating frequent drinking.

For each of the three types of beverages, three questions measuring quantity and variability were then asked in series:

1. "Think of all the times you have had...recently. When you drink..., how often do you have as many as five or six?"

2. "When you drink..., how often do you have three or four?"

3. "When you drink..., how often do you have one or two?"

Quantity was expressed in terms of "glasses" of wine, "glasses" or "cans" of beer, and "drinks" of beverages containing spirits. The response categories were: "Nearly every time"; "More than half the time"; "Less than half the time"; "Once in a while"; and "Never."

These questions on quantity consumed and relative frequency were asked for each beverage which the respondent reported drinking about once a month or more often. The replies permitted classification of each respondent by modal quantity for each beverage

CHART 1.–*Quantity–Variability Classifications*

Quantity–Variability Class	*Modal Quantity (amount drunk "nearly every time" or "more than half the time")*	*Maximum Quantity (highest quantity drunk)*
1	5–6	5–6
2	3–4	5–6 "less than ½ time"
3	3–4	5–6 "once in a while"
4	no mode specified	5–6 "less than ½ time"
5	3–4	3–4
6	1–2	5–6 "less than ½ time"
7	no mode specified	5–6 "once in a while"
8	1–2	5–6 "once in a while"
9	1–2	3–4 "less than ½ time"
10	1–2	3–4 "once in a while"
11	1–2	1–2

CHART 2.–*Q–F–V Classifications*

Q–F–V Group	*Frequency (of any alcoholic beverage)*	*Quantity–Variability Class (beverage drunk most often)*[*]
1. *Heavy Drinkers* (324 persons, 12% of weighted[*] total)		
	a. Three or more times a day	1–11
	b. Twice a day	1–9
	c. Every day or nearly every day	1–8
	d. Three or four times a week	1–5
	e. Once or twice a week	1–4
	f. Two or three times a month	1
2. *Moderate Drinkers* (354 persons, 13%)		
	a. Twice a day	10–11
	b. Every day or nearly every day	9–10
	c. Three or four times a week	6–9
	d. Once or twice a week	5–9
	e. Two or three times a month	2–8
	f. About once a month	1–6
3. *Light Drinkers* (766 persons, 28%)		
	a. Every day or nearly every day	11
	b. One to four times a week	10–11
	c. Two or three times a month	9–11
	d. About once a month	7–11

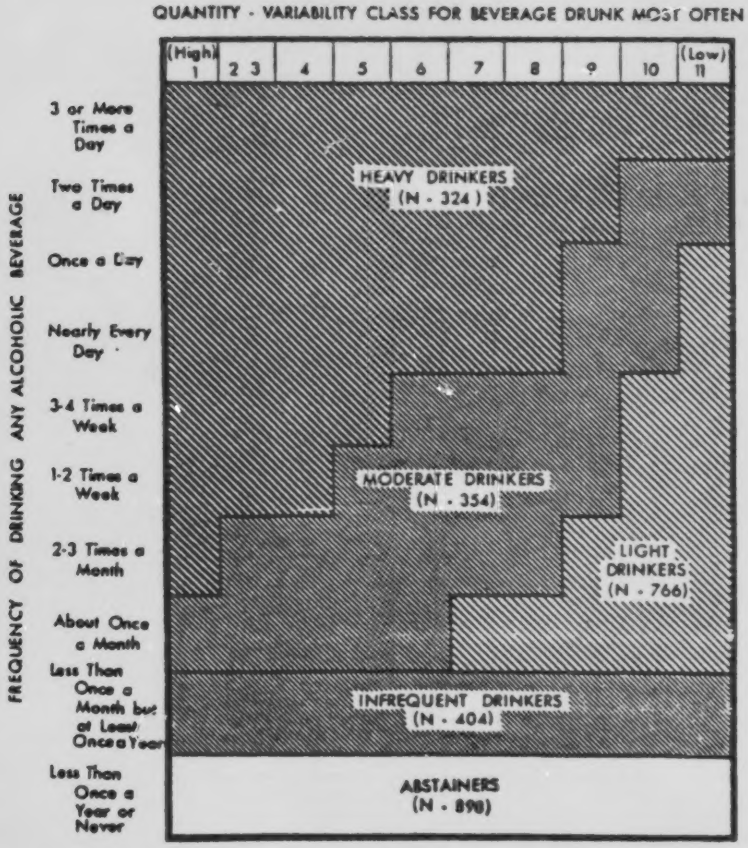
4. *Infrequent Drinkers*

(404 persons, 15%): Drank less than once a month but at least once a year (quantity questions not asked).

5. *Abstainers*

(898 persons, 32%): Drank none of the three beverages as often as once a year (quantity questions not asked).

CHART 3



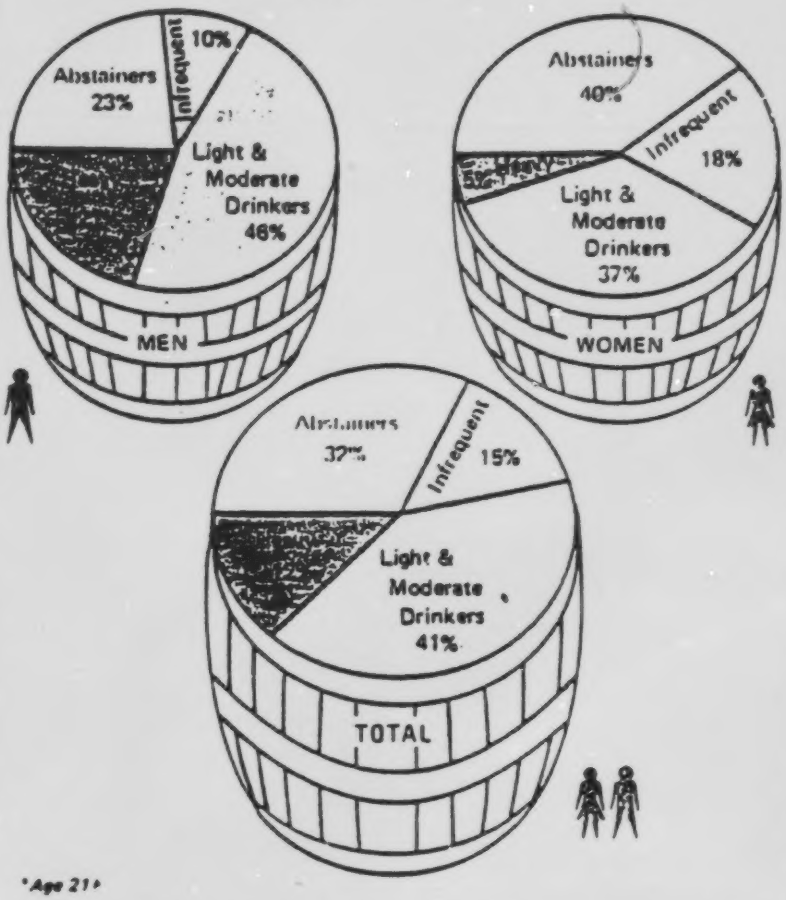
Quantity–Frequency–Variability Classifications

SOME RESULTS OF THE 1964-1965 NATIONAL SURVEY

32% of the total adult population are abstainers. The remaining 68% drink at least once a year, with 12% of all adults classified as heavy drinkers.

77% of adult men and 60% of adult women drink at least once a year, with 21% of all men and 5% of all women classified as heavy drinkers.

FIGURE 1. PERCENT OF ABSTAINERS AND TYPES OF DRINKERS AMONG ADULTS* U.S.A. 1964-1965



**Age 21+*

ᵃ Degree of drinking was classified according to a rather complex combination of the quantity of alcohol consumed per occasion and the frequency of drinking.

- *Heavy drinking. Drink nearly every day with five or more per occasion at least once in a while, or about once weekly with usually five or more per occasion.*
- *Moderate drinking. Drink at least once a month, typically several times, but usually with no more than three or four drinks per occasion.*
- *Light Drinking. Drink at least once a month, but typically only one or two drinks on a single occasion.*
- *Infrequent Drinking. Drink at least once a year, but less than once a month.*
- *Abstainers. Drink less than once a year or not at all.*

NOTE: These are just some of the conclusions described in the book "American Drinking Practices". Many other variables were also analyzed and explained. We will refer you to the book for a more complete review. The purpose of including the above information in this manual was to emphasize the detail involved in the study.

(i.e., the quantity he drank "nearly every time" or "more than half the time") and by the maximum quantity he drank at least "once in a while." Thus a person who said that when he had beer he had one or two glasses or cans more than half the time, but once in a while drank five or more, would be classified as having a modal quantity of one or two and a maximum of five or more.

This two-way approach permitted the quantity-variability classification for each beverage shown in Charts 1, 2, and 3.

NATIONAL SURVEY II

This survey was based upon a subsample of the 1964-1965 study and it included 1,359 reinterviews. Changes were measured covering the three year span of time. Current problem scores were tabulated and correlated with social-psychological scores and demographic variables.

Six social-psychological variables:

1. Attitude toward drinking
2. Environmental support for heavy drinking
3. Impulsiveness and nonconformity
4. Alienation and maladjustment
5. Unfavorable expectations
6. Looseness of social controls

Demographic variables:

1. Age
2. Sex
3. Socioeconomic status (ISP)
4. Urbanization

From these variables, a "risk score" was developed, with "risk" referring to the danger of being a problem drinker. Analysis shows that the social-psychological "risk score" does a fairly effective job of predicting problem drinking -- especially when combined with such independent variables such as those listed above. (See Cahalan, et.al., 1970, p.106.)

NATIONAL SURVEY III

This survey, completed in 1969, reports on a "high risk" group of American men ages 21-59. This group of men constitutes a majority of the working population and holds a large share of economic and political power. There were 978 men interviewed who were not included in the first two national surveys. They were combined with 583 men between ages of 21-59, taken from the second national survey. This sample totaled to 1,561 men age 21-59. (See Cahalan and Room, 1974.)

NATIONAL SURVEY IV

The final stage of national research will be reported on within the next couple of years. It will reinterview subjects from the previous surveys and will permit a more detailed analysis of changes in drinking behavior and problems over a ten year period.

CONCLUSION

The Cahalan research was included in the manual to provide a basis for introducing the Parker G. Marden estimation formula. (See Appendix P) Marden's work is tied directly to the national surveys and will be the primary needs assessment tool discussed in this training workshop.

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MODULE V

MODULE V: BEGINNING THE PLANNING PROCESS **TIME:** 3 HOURS

GOALS

- Provide participants with a conceptual framework for prevention planning and decision-making, as they begin to identify appropriate program objectives for their own communities.

OBJECTIVES:

At the end of this module, participants will be able to:

- Identify and use available prevention needs assessment and planning resources
- Write one possible prevention program objective for their community.

MATERIALS:

- Newsprint
- Magic Markers
- Paper
- Pencils
- Diagrams (Prevention Planning Functions; Needs Assessment Process)
- "Writing Program Objectives"

MODULE V OVERVIEW

EXERCISE	TIME	METHODOLOGY
1. THE PLANNING PROCESS	20 MINUTES	LECTURE/DISCUSSION
2. THE PREVENTION PLANNING MODEL	35 MINUTES	LECTURE/DISCUSSION
3. WRITING OBJECTIVES	45 MINUTES	INDIVIDUAL EXERCISE
4. COMPARING OBJECTIVES	30 MINUTES	LARGE-GROUP EXERCISE

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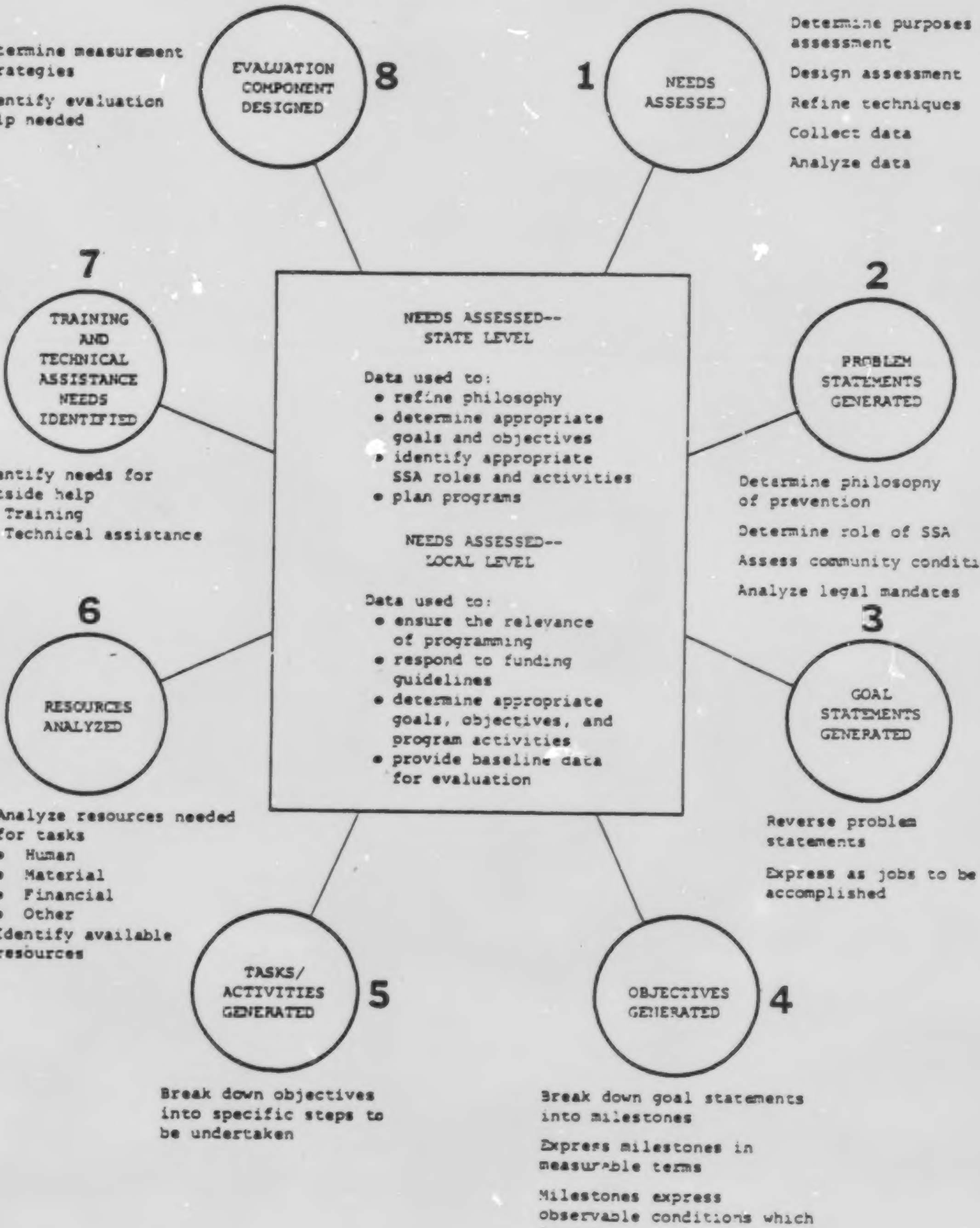
FUNCTIONAL ANALYSIS OF THE PREVENTION PLANNING PROCESS



1
NEEDS ASSESSED
2
PROBLEM STATEMENTS GENERATED
3
GOAL STATEMENTS GENERATED
4
OBJECTIVES GENERATED
5
TASKS/ ACTIVITIES GENERATED
6
RESOURCES ANALYZED
7
TRAINING AND TECHNICAL ASSISTANCE NEEDS IDENTIFIED
8
EVALUATION COMPONENT DESIGNED

NEEDS ASSESSED--STATE LEVEL

Data used to:

- refine philosophy
- determine appropriate goals and objectives
- identify appropriate SSA roles and activities
- plan programs

NEEDS ASSESSED--LOCAL LEVEL

Data used to:

- ensure the relevance of programming
- respond to funding guidelines
- determine appropriate goals, objectives, and program activities
- provide baseline data for evaluation

1 NEEDS ASSESSED

Determine purposes of assessment

Design assessment

Refine techniques

Collect data

Analyze data

2 PROBLEM STATEMENTS GENERATED

Determine philosophy of prevention

Determine role of SSA

Assess community conditions

Analyze legal mandates

3 GOAL STATEMENTS GENERATED

Reverse problem statements

Express as jobs to be accomplished

4 OBJECTIVES GENERATED

Break down goal statements into milestones

Express milestones in measurable terms

Milestones express observable conditions which lead to accomplishment of goal

5 TASKS/ ACTIVITIES GENERATED

Break down objectives into specific steps to be undertaken

6 RESOURCES ANALYZED

Analyze resources needed for tasks

- Human
- Material
- Financial
- Other

Identify available resources

7 TRAINING AND TECHNICAL ASSISTANCE NEEDS IDENTIFIED

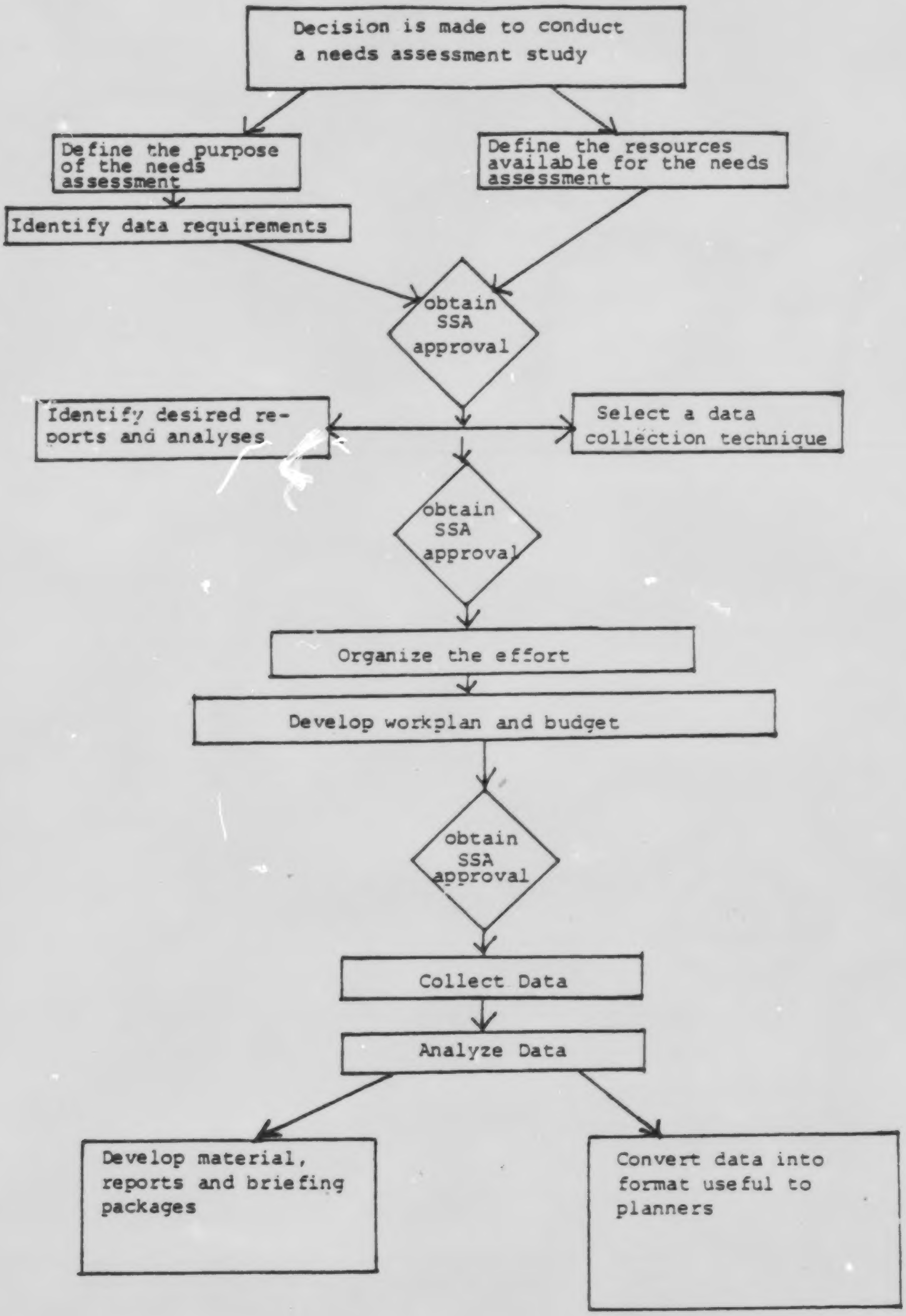
Identify needs for outside help

- Training
- Technical assistance

8 EVALUATION COMPONENT DESIGNED

Determine measurement strategies

Identify evaluation help needed


Decision is made to conduct a needs assessment study
Define the purpose of the needs assessment
Define the resources available for the needs assessment
Identify data requirements
obtain SSA approval
Identify desired reports and analyses
Select a data collection technique
obtain SSA approval
Organize the effort
Develop workplan and budget
obtain SSA approval
Collect Data
Analyze Data
Develop material, reports and briefing packages
Convert data into format useful to planners

NATIONAL DRUG ABUSE CENTER

WRITING SPECIFIC PROGRAM OBJECTIVES

A Self-Instructional Learning Package

Adapted from Basic Management Skills: Resource Manual, pp. 217-249, National Drug Abuse Center for Training and Resource Development, Rosslyn, Va,, 1977.

Worksheet V-2 Continued

INTRODUCTION

This self-instructional module is designed to help you learn how to write objectives that are clear and specific.

When you have completed this learning package, you will be able to do the following:

1. Distinguish a goal from an objective;
2. Identify program objectives that are specific, measurable, and time-phased; and
3. Write program objectives that are specific, measurable and time-phased.

If you are confident that you already know how to write specific program objectives, please take the pretest on the following page. When you have finished, check your results with the trainer. If both your objectives are approved by the trainer, you will have met the objectives of the learning package.

Or, if you prefer, skip the pretest and turn immediately to the instructions on the next page.

* * * * * *

INSTRUCTIONS

Complete each page before turning to the next page. Read the material and answer the question on each page; then turn the page and check your answer.

Now turn the page and begin.

* * * * * *

What is the difference between goals and objectives?

A goal is a general statement of what we intend to do. Because goals are stated in general terms, they can be interpreted in many different ways.

An objective is much more specific than a goal. A well-stated objective leaves little doubt about exactly what will be done, how this will be measured, and when it will be accomplished.

Is the following statement a goal or an objective? "Drug abuse will be reduced."

Answer: ______________________________

If you said goal, you were right. The statement is too general to be a good objective.

If you said objective, take another look at the statement. Does it tell you how drug abuse will be measured, or how much it will be reduced, or by what date?

Is the following statement a goal or an objective?

"The incidence of arrests for drug abuse in Center City will be reduced by 10 percent within one year."

Answer: ______________________________

* * * * * *

If you said objective, you were right. The statement clearly specified what the result would be (incidence of arrests for drug abuse in Center City will be reduced), how this will be measured (reduced by 10 percent) and when (within one year).

In the space below, write the difference between a goal and an objective.

* * * * * *

List below the three essential characteristics of a useful objective.

1.

2.

3.

Now go to the next page.

* * * * * *

Worksheet V-2 Continued

The three essential characteristics of a useful objective are the following:

1. It states specifically the result to be accomplished.
2. It is expressed in measurable terms.
3. It identifies when the result will happen.

Let's concentrate on the first two characteristics of a good objective:

1. It states specifically the result to be accomplished.
2. It is expressed in measurable terms.

Put an X in the box beside each of those statements below that:

- Specifically state a result; and
- are expressed in measurable terms.

1. ( ) Establish drug abuse referral systems in the five largest police departments in this state.
2. ( ) Provide drug abuse prevention training to school teachers.
3. ( ) Design four weekend recreation activities to involve 25 inner city youth.
4. ( ) Reduce drug abuse to a level acceptable to the public.
5. ( ) Conduct a campaign to increase public awareness of substance abuse-related problems.
6. ( ) Increase by two the number of community groups voluntarily contributing goods or services to the drug abuse prevention program on a regular basis.
7. ( ) Reduce by 20 percent the number of drug emergencies at the hospital through drug education in area schools.
8. ( ) Explore formation of a state drug abuse prevention program association.
9. ( ) Initiate an assessment of substance abuse prevention problems in the community.
10. ( ) Establish a peer group rap meeting for junior high students that is acceptable to the students.

You should have placed an X before statements 1, 3, 6, 7, 10.

Take another look at any you missed. Do those statements tell you specifically what the expected result is and how it is to be measured?

* * * * * *

The third characteristic of a useful objective is the time frame, which states exactly when the result will happen, or by what date it will be completely accomplished.

Which of the following statements specify a clear time frame?

1. As soon as possible
2. By the last day of each month
3. Immediately
4. When feasible
5. By July 1, 1977

Answer: ____________________________

* * * * * *

Numbers 2 and 5 specifically state by what time or date we could expect a result to happen. The other statements don't tell us how soon is "possible," when is "immediately" (today? this week?), or how soon "feasible" is.

Useful objectives must specify when a result will happen by stating a date or giving the number of days, months, or years.

List again the three characteristics of a useful objective.

1.

2.

3.

If you are not sure, check your answers.

Worksheet V-2 Continued

Now try to find each of the three characteristics in the objective below.

Objective:

Provide 40 hours of in-service training annually to all elementary school teachers within five years.

1. Underline the parts of this objective that state the intended result.
2. Place a square around the parts that are measurable.
3. Circle the time frame.

* * * * * *

Your answer should look like this.

> Provide 40 hours of in-service training annually to all elementary school teachers within five years.

Now do the same with the following objectives.

    1. Underline the specific result intended.
    2. Put a square around the measurable parts.
    3. Circle the time frame.

1. Develop prevention program objectives that are consistent with the goals of the program within one year.
2. Establish a recordkeeping system for prevention activities acceptable to NIDA by the beginning of the next budget year.
3. Provide 30 hours of training to 350 shop foremen in identifying and counseling potential and actual drug abusers by September 30, 1979.

* * * * * *

The answers are:

1. Develop prevention program objectives that are consistent with the goals of the program within one year.
2. Establish a recordkeeping system for prevention activities that is acceptable to NIDA by the beginning of the next budget year.
3. Provide 30 hours of training each to 350 shop foremen in identifying and counseling potential and actual drug abusers by September 30, 1979.

Write two specific program objectives for your prevention program that you consider important.

Your trainer will give you instructions for checking the specificity and usefulness of your objectives.

MODULE VI

MODULE VI: DEVELOPING COMMUNITY SUPPORT FOR PREVENTION **TIME:** 3 HOURS

GOALS

- Assist participants in identifying critical elements in developing a broad base of community support for their prevention programs
- Write an action plan for achieving this goal.

OBJECTIVES:

At the end of this module, participants will be able to:

- List five factors that promote the acceptance of drug abuse prevention efforts in their communities
- List five factors that hinder prevention efforts in their communities
- Write an action plan for creating community support
- List at least three criteria for success in their efforts to build community support for prevention.

MATERIALS:

- Newsprint
- Magic Markers
- Pencils
- "Helping/Hindering Factors" Worksheet
- CBPS Action Plan Workbook

MODULE VI *OVERVIEW*

EXERCISE	*TIME*	*METHODOLOGY*
1. INTRODUCTION: PREVIEW OF COURSE	5 MINUTES	DISCUSSION
2. THE IMPORTANCE OF COMMUNITY SUPPORT	10 MINUTES	LECTURE/DISCUSSION
3. HELPING/HINDERING FACTORS	45 MINUTES	INDIVIDUAL EXERCISE
4. BUILDING SUPPORT FOR DRUG ABUSE PREVENTION	45 MINUTES	SMALL-GROUP EXERCISE
5. ACTION PLANNING	2 HOURS	INDIVIDUAL EXERCISE

HELPING/HINDERING FORCES

	HELPING FORCES	HINDERING FORCES
INDIVIDUAL		
ORGANIZATION		
COMMUNITY		

ACTION PLAN OUTLINE

1. Community Description
2. Evidence of a Problem
3. Project Goals/Objectives
4. Helpful and Hindering Factors
5. Your Role
6. Resources
7. Implementation Strategy
    a. determine alternatives to achieve objectives,
    b. select two alternatives, and
    c. list steps to implement first choice.

Please enter the appropriate information on paper, using each of the headings listed above, and as much or as little space as you require.

OUTLINE EXPLANATION

1. *Community Description:* Enter a description of the socio-demographic characteristics of the community your program serves. Items you might mention include geographical terrain; population size, age, sex, race, ethnicity, income, education, occupation, geographical distribution; and any other characteristics of the community. Do not concentrate on a specific subcommunity toward which your program is directed.

2. *Evidence of a Problem:* What is the specific evidence (indicators) of a substance abuse problem in your community? What evidence indicates a need for a prevention program? For each piece of evidence you list, designate and describe the "target groups."

3. *Project Goals:* Think out a problem. Concentrate on a situation you want to work on and believe you can change. Write your problem as a positive statement. This becomes your goal. Your goal and its objectives should outline exactly what you are trying to do, how situations will

change when your program has affected the community, and how you will know when you have succeeded.

4. *Helpful and Hindering Factors:* Enter the factors you have identified as helpful to your project's implementation and operation and those factors you view as hindering your efforts.

5. *Your Role:* Address the following three items:

   - Your conception of your role as a prevention specialist,
   - Changes you would like to make in your job description to facilitate implementation of this plan, and
   - Necessary competencies that you have identified and you do not possess already.

6. *Resources:* What are the resources you will need to implement your plan? Do you need people, space, things, time, and/or money? Are these resources available? Where are you going to search for additional resources?

7. *Implementation Strategy:* Describe how you plan to overcome each hindering factor that was identified in Step #4. List the sequence of activities you plan to follow in implementing your project:

   a. List a number of alternatives for achieving the goal.

   b. Select two alternatives to explore and test.

   Use the analysis sheet to examine each for practicality and feasibility. Analyze the others using the same process. Based on your analysis, select one as the First Choice Alternative.

   c. List all the steps necessary to implement the First Choice Alternative.

8. *Evaluation:* How will you know that your plans are in need of revision? What are the costs of your activity? What new problems are created? What are you going to measure? Who is going to do the measuring? How will you know if you have achieved your goals and objectives? Which evaluation instrument(s) could be used?

ACTION PLANNING EXAMPLE:
THE SIX ACTION PLANNING STEPS
FOR PROGRAM IMPLEMENTATION

Although many activities must be performed to implement a plan, action planning can be divided into six major steps. The six steps are listed below. To illustrate these steps we have chosen a hypothetical problem--one related to a need emphasized in this course, i.e., the provision of child-care services.

1. *Think out a problem. Concentrate on a situation you want to work on and believe you can change.*

   In Bullwinkle, USA, adolescents frequently are suspended from school because of drug-related incidents. If an alternative program were offered, adolescents would not have as much time to be on the streets where drugs are available.

2. *Write out the problem as a positive statement. This becomes your goal.*

   The goal is to decrease by 30 percent the number of junior high school drug-related disciplinary suspensions by providing an alternative drug education program for eight evening sessions, or one semester.

3. *List a number of ways (alternatives) to achieve this goal.*

   a. Make a classroom in the school building available two times a week for a drug education program. Have a community-based prevention specialist and/or a counselor from the drug treatment center (DTC) conduct the course.

   b. Use the community center for sessions.

   c. Meet in a parent's home and have parents responsible for the sessions with the assistance of the CBPS.

   d. Incorporate students into already existing community programs, such as 4-H, Boy Scouts, or Girl Scouts.

4. *Select two alternatives to explore and test. Use the analysis sheet opposite and examine each for practicality and feasibility. Analyze the others in the same way. Based on your analysis, select one for your* First Choice Alternative.

   Based on all factors (time, money, and ability to implement), Alternative One appears to be the best choice; however, other drug treatment center staff might want to work on the next most feasible alternative.

5. *List all the steps necessary to implement the* First Choice Alternative.

   To implement Alternative One, we must:

   - Approximate how many students will be in the program each semester.
   - Consult the school principal, school board, and superintendent.
   - Arrange for the scheduling of classroom space.
   - Design a program allowing for student entry at any time during the semester.
   - Check with the drug treatment center for the availability of a counselor.
   - Design an alternative drug education curriculum.
   - Contact parents and advise students of new program.
   - etc.

6. *Delegate responsibility for each step to be taken; get commitments from the people who are going to help; assign a completion date for each task; identify factors (events, changes) that will indicate completion. Establish ways of evaluating the first action steps in order to plan succeeding ones.*

GOAL	ALTERNATIVE ONE	ALTERNATIVE TWO
To decrease by 30% the number of drug disciplinary suspensions of Jr. High students by providing an alternative Drug Education program for 8 evening sessions.	*Use a classroom at the school for sessions conducted by the CBPS and/or a counselor from the local drug treatment center.*	*Students will choose from a list of existing community alternative activities programs, such as Boy Scouts/Girl Scouts, 4-H, etc., to attend for one semester (or equivalent time).*
• **HOW PRACTICAL IS IT TO IMPLEMENT IN YOUR PROGRAM?**	*Seems very practical. The classroom is available at no charge and the CBPS is available to staff sessions. Will have to check with the DTC for availability of a counselor and whether or not a fee will be required for his/her services.*	*Seems like a good idea considering all the available resources in our community.*
• **CAN YOU IMPLEMENT IT OR DOES IT REQUIRE ADDITIONAL RESOURCES?**	*I can arrange to have the classroom. I can schedule days and time of sessions to have CBPS available. I can find out the availability of a counselor from the DTC to assist the CBPS.*	*We will need the cooperation of local resources to place the students. Within two weeks, a list of possible organizations can be compiled and telephone contact to each can be made to assure cooperation. Parents will need to be informed of program and schedule of meeting times as well as general information about the organization. A meeting of all group leaders would be helpful in understanding our program goals.*
• **WHAT KINDS OF RESOURCES ARE NEEDED?**	*Scheduling of classroom and CBPS could be done in a couple of days. CBPS would probably need a couple of weeks to plan the 8 sessions. Providing no fee is involved, the counselor from DTC could be contacted and available in 1 week. Paper and duplication for schedule of sessions for students and parents. Phone contact to parents about the program could be completed in a week.*	*We will need additional resources. The local organizations will have to be willing to accept our students and understand our program goals.*
• **HOW LONG WILL IT TAKE TO IMPLEMENT?**	*It will take approximately 2-3 weeks.*	*Approximately 3 weeks.*
• **WHAT PROBLEMS WILL BE CREATED (HINDERING FACTORS)?**	*Having students on the streets after dark if parents are not available to transport them. Sessions will need to be designed so that students can come into the program at any time during the 8 weeks.*	*Local organisations unwilling to accept students into their group. Fees or dues required of the group members. Transportation to/from meetings. Having peers who have been involved in drugs join the group. Lack of skills and knowledge to function adequately in the group.*
• **DO THE POTENTIAL BENEFITS OUTWEIGH OR EQUAL THE POTENTIAL LIABILITIES?**	*YES*	*NO*

ACTION STEPS NEEDED TO BEGIN WORK ON FIRST CHOICE ALTERNATIVES

Question	Action 1	Action 2	Action 3	Action 4
WHAT IS GOING TO BE DONE? (ACTION STEPS)	*Collect information to estimate number of students who will be taking the course.*			
WHO IS GOING TO DO IT? (PERSONS WHO WILL ASSIST IN IMPLEMENTING PLAN)	*Ann S.*			
WHEN IS IT GOING TO BE DONE?	*By 2/6*			
WHY IS IT GOING TO BE DONE?	*To have enough information to determine size of classroom & number of materials & instructors needed.*			
WHAT CRITERIA WILL INDICATE THAT IT WAS BEEN DONE?	*Report of estimate of number of students.*			

ACTION PLANNING OVERVIEW

1. **Purpose**

   Action planning serves to provide a framework for effecting change in a program's structure, process(es), or function(s).

2. **The Six Action Planning Steps**

   The Action Planning Workbook follows these instructions. Refer to it for an introduction to the steps involved in action planning. Take notes in the space provided.

   a. Think out a problem.

   b. Write out the problem as a positive statement.

   c. Brainstorm and list ways (alternatives) to achieve this goal.

   d. Select two alternatives to explore and test.

   e. List all steps necessary to implement the first choice alternative.

f. Delegate responsibility for each step.

g. Identify necessary action for plan approval.

3. Additional Notes

I. PROGRAM GOALS

State the goal of your program.

____

____

____

II. PROBLEM STATEMENT

Think out a problem. Concentrate on a situation you want to work on and believe you can change.

____

____

____

____

III. GOAL STATEMENT

Establishing a realistic goal is a very important part of your personal action plan; without it you cannot prepare a plan for action. Write a goal by stating the problem in terms of what you want to accomplish. The mechanics for achieving this goal follow in subsequent steps.

Goal Statement: ______________________________

____

____

IV. ALTERNATIVES

Can you think of three ways to achieve your goal? Try to think of three completely different alternatives to help you reach your goal. Since this is a form of personal "brainstorming," try not to evaluate the alternatives as you think of them; save that for later.

Rewrite your goal statement: ____________________

____

Alternative ways to achieve your goal statement:

1.

2.

3.

V. EXAMINING ALTERNATIVES

A. Choosing Alternatives

Look over the three alternatives you have listed. Choose the two you find most practical. Write them in the space provided on the analysis sheet opposite. Then, answer the questions for each alternative.

GOAL	ALTERNATIVE ONE	ALTERNATIVE TWO
• HOW PRACTICAL IS IT TO IMPLEMENT IN YOUR PROGRAM?		
• CAN YOU IMPLEMENT IT OR DOES IT REQUIRE ADDITIONAL RESOURCES?		
• WHAT KINDS OF RESOURCES ARE NEEDED?		
• HOW LONG WILL IT TAKE TO IMPLEMENT?		
• WHAT PROBLEMS WILL BE CREATED (HINDERING FACTORS)?		
• DO THE POTENTIAL BENEFITS OUTWEIGH OR EQUAL THE POTENTIAL LIABILITIES?		

Choose one of the two alternatives as a result of the answers to the six questions. Indicate below why you chose that particular alternative. This becomes your *First Choice Alternative.*

FIRST CHOICE ALTERNATIVE

My **First Choice Alternative** *to achieve my goal of*

____

is ____

____

____

B. Obtaining Support

Before planning specific steps to implement this alternative, consider the following restraining forces that may affect this choice. Keep your answers in mind as you plan your action steps.

1. *Who will determine whether you will be able to carry out any plan when you get back to your job?*

	Name	Function	OK Needed?
a.			
b.			
c.			

2. *What factors (helpful or hindering) on the job will influence your success or failure in implementing your* First Choice Alternative?

	Factor	Helpful	Hindering
a.			
b.			
c.			
d.			
e.			
f.			

Factor	Helpful	Hindering
g. ______________________________	_______	_________
h. ______________________________	_______	_________

How to change hindering to helpful. ________________

____

____

VI. ACTION STEPS

The process for implementing the *First Choice Alternative* is broken down into action steps. List these action steps below.

Action Step Breakdown of *First Choice Alternative*

Action Step 1:

Action Step 2:

Action Step 3:

Action Step 4:

When you have identified the action steps required to solve the problem, write them in the top four boxes on the chart on the following page.

VII. DETAILS OF PLAN

Complete the details of your plan on the chart opposite. Delegate responsibility for each step to be taken; get commitments from the people who are going to help; assign a completion date for each task; identify factors (events, changes) that will indicate completion. Establish ways of evaluating the first action steps in order to plan succeeding ones.

ACTION STEPS NEEDED TO BEGIN WORK ON FIRST CHOICE ALTERNATIVES

Question	Action 1	Action 2	Action 3	Action 4
WHAT IS GOING TO BE DONE? (ACTION STEPS)				
WHO IS GOING TO DO IT? (PERSONS WHO WILL ASSIST IN IMPLEMENTING PLAN)				
WHEN IS IT GOING TO BE DONE?				
WHY IS IT GOING TO BE DONE?				
WHAT CRITERIA WILL INDICATE THAT IT HAS BEEN DONE?				

MODULE VII

MODULE VII: GETTING THE NEWS OUT TIME: 3½ HOURS

GOALS

- Familiarize participants with the concepts of formal and informal communications networks
- Assist them in developing realistic strategies for utilizing those networks within their own communities.

OBJECTIVES:

At the end of this module, participants will be able to:

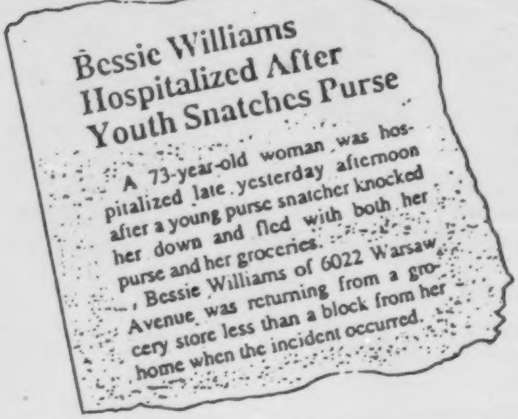
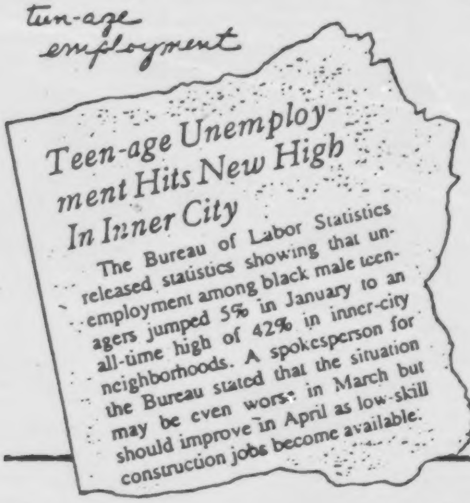
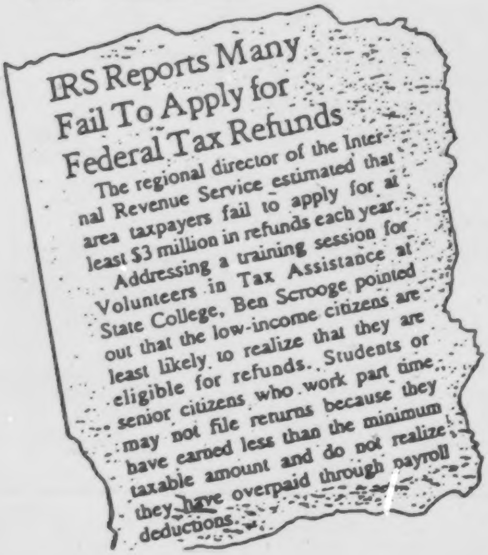
- Define formal and informal communications networks and differentiate between the two
- Identify the significant formal and informal communications networks within their own community
- List at least three strategies for utilizing their community information dissemination networks to develop drug abuse prevention activities
- Develop a media piece appropriate to their own program objectives.

MATERIALS:

- Newsprint
- Magic Markers
- Pencils
- Daily newspaper

MODULE VII OVERVIEW

EXERCISE	TIME	METHODOLOGY
1. INTRODUCTION: REVIEW	10 MINUTES	LECTURE
2. WHAT'S THE BUZZ?	20 MINUTES	SMALL-GROUP EXERCISE
3. FORMAL AND INFORMAL COMMUNICATIONS NETWORKS	15 MINUTES	LECTURE/DISCUSSION
4. IDENTIFYING INFORMAL COMMUNICATIONS NETWORKS	30 MINUTES	INDIVIDUAL EXERCISE
5. FORMAL COMMUNICATIONS NETWORKS	30 MINUTES	LECTURE/DISCUSSION
6. USING YOUR MEDIA	20 MINUTES	SMALL-GROUP EXERCISE
7. FORMAL COMMUNICATIONS NETWORKS	30 MINUTES	LECTURE/DISCUSSION
8. MAPPING YOUR FORMAL COMMUNICATIONS NETWORK	30 MINUTES	EXERCISE
9. DEVELOPING A MEDIA PIECE	1 HOUR	SIMULATION
10. MOBILIZING THE COMMUNITY	30 MINUTES	LECTURE/DISCUSSION
11. BUILDING YOUR COMMUNITY GROUP	15 MINUTES	SMALL-GROUP EXERCISE
12. WRAP-UP	15 MINUTES	LECTURE

Needs	Brainstorming	Action(s) Planned
Crime prevention  **Bessie Williams Hospitalized After Youth Snatches Purse** A 73-year-old woman was hospitalized late yesterday afternoon after a young purse snatcher knocked her down and fled with both her purse and her groceries. Bessie Williams of 6022 Warsaw Avenue was returning from a grocery store less than a block from her home when the incident occurred.	Vigilante force to patrol Deliver groceries to elderly Ask Department of Human Resources to provide vans or cabs Use school bus to take elderly shopping once a week Go to stores with elderly shopper	Set up escort service for elderly citizens
teen-age employment  **Teen-age Unemployment Hits New High In Inner City** The Bureau of Labor Statistics released statistics showing that unemployment among black male teenagers jumped 5% in January to an all-time high of 42% in inner-city neighborhoods. A spokesperson for the Bureau stated that the situation may be even worse in March but should improve in April as low-skill construction jobs become available.	Join the army Set up a business staffed by teenagers Give workshops on job hunting-- where to look, how to fill out applications, being interviewed Write letters to biggest employers asking them to hire teen-agers	Setup a job bank for teen-agers; require all who register to take part in a workshop on job hunting
Tax assistance  **IRS Reports Many Fail To Apply for Federal Tax Refunds** The regional director of the Internal Revenue Service estimated that area taxpayers fail to apply for at least $3 million in refunds each year. Addressing a training session for Volunteers in Tax Assistance at State College, Ben Scrooge pointed out that the low-income citizens are least likely to realize that they are eligible for refunds. Students or senior citizens who work part time may not file returns because they have earned less than the minimum taxable amount and do not realize they have overpaid through payroll deductions.	Give course on filing for refunds Interview students who work to make sure they are filing Put up posters in schools and senior centers telling people to file Set up free tax advisory service	Write IRS to set up VITA training course

"A Nose for Needs"
FROM SYNERGIST,
SPRING 1979,
NSVP, Washington,
D.C.
20525

DEALING WITH THE PRESS AND MEDIA

Prepared by

Leslie J. Yerman

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DEALING WITH THE PRESS AND MEDIA

The press and broadcast media can be an important asset in getting your message across to the public. There are a variety of ways they can be used and there are a number of steps you should take to insure optimum use.

I. Identifying Contacts

The single-most important tool for publicizing agency activities is the press list. A full, complete list of contacts is essential if you are going to communicate your message. Your contact list should include home and business telephone numbers, as well as home and business addresses. There are several different types of contacts, all of which should be explored.

A. Daily Newspapers

You should determine which daily newspapers are read in your area. Press contacts should include the local (city desk) editor, as well as reporters who cover issues related to your program. Editorial writers should also be on your list.

B. Weekly Newspapers

Every area has weekly or bi-monthly newspapers aimed at a localized population. In large city areas, these may be county-wide; in rural areas, they may cover a smaller area. You should include specialized reporters along with the news editors and editorial writers.

C. Specialized Publications

Research out whether there are newspapers, newsletters, or periodicals that might be good forums for your agency. These might include: university newspapers or magazines, community group or government/ private agency newsletters, etc. Identify a contact at each of these publications.

D. Radio

You should include all radio stations, AM and FM, in your listening area. Many stations may not have a large listening audience but may cater to a group whom you might want to reach, i.e., students, Spanish-speaking Americans, women, blacks, etc. Your list should include the names of local news editors and special interest correspondents. Most small-to-medium sized stations will use your Public Service Announcements (PSAs). Larger stations are more selective. Include the name of the Public Service Director (large stations) and name of the station manager or program director (small/medium stations) on your contact list. In larger areas, radio stations have a number where you can record a news item for broadcast. This is an extremely important number to have.

E. Television

In larger metropolitan areas, television contacts should include all stations. If the stations have correspondents who handle your specific subject needs they should be included along with the local editor. In rural areas, the television list should include any local cable programming along with the stations received from the nearest city. The same advice regarding Public Service Announcements (PSAs) for radio applies to television. Most television stations have a Public Service Department.

F. Wire Services

You should determine the local and state editors, as well as special reporters at Associated Press (AP) and United Press International (UPI). Using the wire services helps to cover any contacts you may have missed, but it is not a substitute for a thorough press list.

Developing your press list can be done in several ways. The simplist is by using the "Yellow Pages," which will help you identify newspapers, magazines, and radio stations. In addition, there are reference books which list newspapers and media (radio and TV) and can be found in larger libraries. A search should be made of local universities, special institutions, and community groups to determine which are apropos for your program.

Once a basic list is compiled, you should telephone the publication or station to determine address, phone, deadline (time by which information must be received to be published or broadcast), and names of special contacts. This information should then be used to develop the formal press list. It should be broken down by type of press or media. Within each category, you should have names, addresses, phone numbers, and deadlines. It might also be helpful to type up sets of labels with names and addresses of contacts, to assist you when you have to get news out quickly.

II. Getting Your Message to the Public

Although you may want to keep the community informed of your agency's programs, not everything you will have to say will be news. It is important to make this differentiation.

News is an event or information of a one-of-a-kind nature. If you do not choose what is newsworthy carefully, you will find that the press and media will shy away from coverage or just ignore your agency altogether. In other words, the person or persons responsible for your agency's press/media relations will have to have, or develop, some sophistication about what is really "news." -- and a certain amount of restraint in terms of how much of your message you try to sell as news. This is another reason why using the Public Service Announcement is advantageous.

A. Disseminating Ongoing Activities of the Agency

Even when there are not special news events, it is important to keep the community aware of your agency's activities. There are numerous devices for creating and maintaining this information.

1. Public Service Announcements - As previously mentioned, both radio and television stations must provide a certain amount of free time for public service messages. Such time is an excellent free forum for your agency to inform citizens of your services, hours, programs, etc.

2. Public Affairs Programs - Television and radio stations must, by FCC regulations, schedule public service programming as part of their community responsibility. Determine what there shows are, who produces them, when they are aired, and the size and composition of their audience. A local radio question-and-answer show can give your agency maximum exposure, even when a specific news event is not taking place.

3. Columns/Articles - The development of a bi-monthly or monthly column by your agency's chief executive officer is often welcomed by weeklies and newsletters.

   Dailies, as a rule, do not use such columns. Such a column should be short (usually no more than 300-500 words), but informational; and can provide a continuing link between you and the public. In addition, you should, when appropriate, approach periodicals with possible article ideas (present them in outline form).

4. Public Speaking Program - Making staff available for public conferences and meetings is another way to get your program's message to the public. When an agency member is going to make such an appearance, it should be accompanied by a short announcement to the press, at least 24 hours in advance.

B. The Press Release

1. Its Uses

The press release is the second-most important public relations tool. It is second only because it is ineffective without a thorough list of press contacts. Press releases have a multitude of uses. They can be used to announce an event or press conference, to disseminate a piece of news, or just inform the press and media of some agency activity.

The press release must be used in a discriminating manner. Its distribution should be dependent on its importance. If it is just an informational item, it might go just to the wires, weeklies, and community groups. If it is a major story, it should go to everyone. When announcing an event or major news item, the release should be backed up by phone calls to major news sources. Sometimes, you will not have the time to distribute the release and will have to call sources and read it over the phone.

2. Writing the Press Release - It is essential that the press release is succinctly written and that it contain only essential information. If your agency has a letterhead or can create one for press needs, it will be helpful.

Every press release, regardless of its content, must have the following information: (a) the release time, i.e., when the information is to be made public, and (b) the contact, i.e., the person (with phone number) to be contacted for further information. Usually, this data is set up towards the top of the release in block letters, as follows:

FOR RELEASE:

CONTACT:

The "for release" date is not necessarily the date the release is written. That date should appear at the end of the text.

The press release should be brief but also should cover all necessary details. Usually, a press release should not run over two pages. If it is summarizing or highlighting the important, i.e., newsworthy points of a bulky document or report, you should always make that information available as an attachment to the press release.

Reporters will not have the time nor the inclination to wade through a long press release. Your first paragraph is the most important. Oftentimes, it will determine whether the information is reported at all. The best hint for the five (5) "W's" of basic journalism: who, what, where, when, and why. Once this information has been established in the initial paragraph, the remaining text can be used to expand on the details. The first paragraph tells the reporter whether or not the item is newsworthy and worth pursuing. A good quote is a must and should appear in the second or third paragraph.

3. The Press Conference - The press conference is used for presenting important information at a forum for all press and media. It is a device for getting maximum news coverage of an issue/event, and therefore should be used only when the data is of maximum importance and interest. Interest is underlined because what may seem of maximum importance to your agency is not necessarily of maximum interest to the public. Do not drag reporters to a press conference unless it is worth their while or they may not come the next time.

a. Planning the Press Conference

Unless a press conference is held to deal with an emergency, press and media must be informed a day or two in advance. A brief press release should be sent out detailing time, date, place, and subject. Announcements should be followed up by phone calls on the afternoon before or morning of the conference. Oftentimes, problems occur and the time may have to be changed. If you cannot contact everyone by phone, you must, at least, call the wire services and they can relay the information to the papers and stations.

If you do not have a meeting room in your agency, attempt to locate a comfortable, central facility such as a city council chamber, auditorium, etc. Make sure that the room you use can be easily arranged for TV cameras, lights, and sound equipment; and that there are plenty of electrical outlets. Nothing upsets a broadcast reporter more than attending a press conference in a place that cannot meet his/her needs.

The time of your press conference should depend on your desired impact. A morning press conference (10 AM) will make that afternoon's papers, as well as the radio and TV stations. An afternoon conference (2 PM) will get the news on to the radio right away, but put if off until the morning papers. Although it is impossible to judge what news a day will bring, Mondays and Fridays are your best bets for coverage. Monday mornings tend to be slow; Fridays provide news for weekend papers.

b. Format

Press conferences, like press releases, should be short and to-the-point. It is best to have a single person present the information. However, if there must be a group of people, make sure, in advance, that each one's presentation is measured, succinct, and non-repetitive. You want to stimulate the interest of the reporters, not bore them.

If a dry run is not possible, you should, at least, "brainstorm" your presentation. Make sure you have all appropriate notes and visual aids necessary. The information must be made in a spontaneous manner with the spokesperson keeping eye contact with the press; it should not be read verbatim.

After the presentation is made, questions should be permitted by reporters. Try to know your material well enough so that you can forsee lines of questioning and bring appropriate data and backup for answers. Attempt, at all times, to keep in control of the press conference. Do not let an aggressive reporter put you on the defensive or your reaction, rather than your information, will become the story. Keep your answers short; a solid, newsworthy answer in 30-45 seconds will be used by radio and TV reporters; a "brilliant" two-minute answer may not be used.

BROADCASTING

AND

BROADCASTERS

BROADCASTING and BROADCASTERS

. . . going on the air

The broadcasting industry--both radio and television--can be of great benefit to you in getting your message across to your entire community. In many instances, use of these media will have wider coverage and wider appeal than the use of the press. And, it should be considered as a definite complement and adjunct to all of your printed publicity.

Broadcasting should be considered for both news coverage and for public service coverage.

Depending upon the news-worthiness of your activities, both radio and tv may be used. This may take the form of a brief mention of your activities through the news releases you feed them; participation on an interview show or panel discussion or actual coverage, by their staff, of an event you are sponsoring. However, you should not confuse "news" with a "plug."

Many local tv outlets carry a local news segment to correspond with the network news broadcast nightly. More often than not they need local news segments to fill their time segment.

If the story warrants it, they may be willing to follow such a story (or in your case in a program or project) over an extended period of time.

Radio stations generally feature local news live, read by a staff announcer, so that your standard news release (not press release) can be included in their regular programming. They may also have scheduled news features such as a community calendar of events which you should use with regular updated fact sheets.

The best way--almost the only way--that you will know each station, either radio or tv, is to listen to them and to watch them. How do they present their local news? Who works with local groups? Do they use reporters as narrators or reporters on-the-spot?

The other areas where you can utilize the broadcasting industry is through "public service" time. Air time and facilities are "given" to worthwhile projects and programs--both on the local and national level. Whether a spot announcement or an extended telethon, many agencies and community-based organizations depend upon broadcasting for their promotion efforts. Obviously, with the competition of all the non-profit agencies, organizations and charities, the time allowed to each must be limited.

There is no legal obligation for a station to carry public service messages. Such programs and announcements will, however, look good on a station report of public service activities when it applies to the Federal Communication Commission (FCC) for renewal of the station's license. Thus, you have a better than average chance of getting air time if you can show the station manager, that your program or message is in the community's interest. Their "time" is money. They cannot schedule P.S. spots in the same way as their commercial spots. Therefore, your message must be important and its presentation in the best possible--and professional--form.

Basically, public service programming falls into two broad categories:

Programs

Specials: interviews, panel discussions, etc., in a one-time or series presentation.

Segments: similar to specials, but of shorter duration, and used with the station's regular program format.

On-the-Air Exposures

Editorials: statements written by the station to reflect its viewpoint and rebuttals from interested persons or organizations.

Spots: announcements (10, 20, 30 or 60 seconds each) which are made at various times during a broadcast day (either live or on tape or film).

News inclusion: "Community Calendars," etc. as a feature within the regularly scheduled newscast.

Do not be overcome by the aspect or the "aura" of working with professional broadcasters. They are, indeed, professionals at their work, but they require most of all professional courtesy. Respect--first and foremost--of their time. A station's product is time; it cannot be expanded to "fit" like a newspaper's space. The pressures to meet deadlines are more intense. If time is money, don't waste it. Be prompt for any appointments or interviews; have your material ready; invite these media people to your activities or events as "guests"--not reporters--and write thank-yous as well as agency staff or community reactions to any coverage they may give you. Although these tips may appear not only professional courtesy but common courtesy, they are too often overlooked in the day-to-day working relationships in this fast-paced business.

When you have familiarized yourself with the program format of the various stations, write or call to make an appointment with the station's program director. (In some stations there may be other individuals you will see also--or instead--public service directors, news director, producers, etc. This will vary with the station, but generally the program director will act as your coordinator and steer you in the right direction to the right person.)

Be prepared with written materials on your agency and its activities. (Your interview may have to be passed on to someone else, and a lot can be lost in the translation.)

This can be in the form of a fact sheet outline which includes the people or segment of the community your agency currently serves, the program and the progress you anticipate as a result of your intervention. Don't feel that you have to come up with a script or a scenario--leave that to the pros. They will welcome suggestions; but will know what is "workable," in terms of both time and talent.

RADIO
. . . the spoken message

In considering radio as a means of getting your message across, consider the fact that more than 98% of American homes have at least one radio. Consider that radio is in the home, in the car, in many offices and most recreational areas. It reaches all ages and kinds of people--teenagers, housewives, factory workers, businessmen, etc. Consider reaching them through the best use of what radio has to offer--news, music, sports, short interview segments, editorials, and special features. Consider that radio uses a great deal of public service coverage, both on the national level as well as the local. And consider too that radio is very personal and direct.

Although there are some general rules about broadcasting copy, tapes, etc., check with each station to see what their individual requirements are. Some may want only a fact sheet, some will want prepared copy, some may want everything on tape. However, some general rules apply.

Radio relies upon the spoken word so all copy must rely on sound rather than sight. Read and listen to your copy. It should sound like conversation. If you use "can't" in everyday speech, don't use "cannot" in your copy. Sentences should be short. Sentence structure should be confined to one complete thought. However, use some variation in the length of the sentences to avoid a staccato or sing-song reading. One or two longer sentences will give adequate pacing.

Avoid alliteration (wild & woolly, hot & heavy, etc.) or a series of similar words which become tongue twisters for the announcer. By including such phrases you aren't writing poetry or the Great American Novel, you are merely presenting a reading hazard.

Again, make things as easy as possible for the announcer by structuring your writing to show natural breaks and pauses. (You can do this by using a series of dots or dashes rather than the normal use of commas, semicolons, paragraphs, etc.)

For instance: "Clean-Up, Fix-Up, Paint-Up Day" . . . sponsored by the Tampa Housing Authority . . . will be held on Saturday, November first.

If there are names which are difficult to pronounce, show the phonetic spelling, in a parenthesis and in caps:

"Executive Director of the Authority, Mr. Noreaga (NOR-REE-A-GA)said . . ."

Although the copywriter must generally write copy geared for a particular medium and a particular audience, don't attempt to write for a particular area which is not familiar to you. For instance, the local disco D.J. will have a unique style of delivery using idiom, slang and certain "in phrases." You don't have to try to imitate this style; in fact you shouldn't even try! If your copy meets his needs for facts and usage, he will use it and the delivery will be uniquely his.

A most important thought on all broadcasting copy: keep time in mind. Time your copy by reading it aloud to yourself at a natural speaking pace. Try this several times using a stopwatch or a watch with a second hand.

In broadcasting, ten seconds means ten seconds--not nine, and certainly not eleven. If you have exceeded your time, cut! Every word takes time to speak--and unnecessary adjectives will take time away from your message. Words per second can be approximated as follows:

10 seconds - 25 words
20 seconds - 50 words
30 seconds - 75 words
60 seconds -150 words

If you are submitting "news" to a radio station, make sure it is, in fact, news. Most stations must cover the news of the world, the nation and the local scene in a five-minute segment. Obviously, they can only hit the highlights. Radio news must be informal, conversational, brief and to the point. But the most important element is accuracy. Once spoken, errors cannot be recalled and corrected. If you have a news item, use it. But it might be a good idea to use a fact outline only for these newscasts and depend on expanded copy for inclusion in a different type of format--community calendars, editorials, etc.

The mechanics of preparing copy for radio are not that different from those of print:

- All copy type on 8-1/2" x 11" white paper, double or triple spaced.
- Stations may request duplicate copies, but never on onion skin paper (it rattles and the noise will be picked up over the air)
- Identify your group and contact person in the same way you did for press releases
- Give "use" dates: For use between Monday, November 1 thru Saturday, November 6, etc. rather than the standard "For Immediate Release" used in press releases
- Do not abbreviate words which might be misread, i.e., phone numbers such as FE might be FEderal or FEntworth. Also, addresses must be spelled out. N.W. should be spelled "Northwest" so that the reader will pick it up immediately
- Make sure that you have given the phonetic pronunciation of all difficult-to-pronounce words and names.

Remember, you are trying to make the announcer's job as easy as possible. Without this extra time and effort, your news or your spots may never be heard.

If you or other personnel from your agency are invited to participate in an interview--either live or taped in advance--go prepared. Submit information in advance to the station. Make sure that all group members are "prepped" on what is to be covered. Try to arrive at the station at least a half hour before air time to receive instructions, to meet the station staff you will be working with and for any last minute instructions and rehearsing.

Station personnel will go over the techniques and technicalities: how to speak into the mike, how to handle copy so that it doesn't make extra noise, how to respond to questions in a natural way. You will probably be nervous, everybody is! Try to imagine that you are speaking to one particular person; the microphone becomes a telephone. What could be easier than talking on the telephone to your best friend?

Radio Spot #l shows a typical radio spot including the necessary mechanics of preparation.

RADIO SPOT #1*

Project SOAK (Summer Outdoor Activities for Kids)
P.O. Drawer PP
Santa Barbara, California 93109

For Further Information, Contact: Buster Crabbe, 936-6673

For Broadcast: Monday, May 20 Through Saturday, May 25, 1979

LEAD IN: "Sumertime Blues" by Vanilla Fudge. THERE IS A CURE FOR THE SUMERTIME BLUES! Project SOAK is here to keep you cool and comfortable this summer - we'll pick you up, take you to the beach, and teach you swimming in the bargain.

If you'd like some fun this summer, free of charge, are between 6-14 years old and live within the city limits of Santa Barbara, call Buster Crabbe at 936-6673. Take the dive, today.

*Copy for this announcement was written by the staff of the Department of Human Services, Santa Barbara, California.

TELEVISION

. . . the visual medium

Television, unlike any other medium, can offer infinite variety--the printed word, the spoken word, still pictures, motion pictures, music, animation, sound effects and personal contact. It can tell a story pictorially, graphically, instantly--in a 60 second news clip, a documentary film or an interview show. Like radio, tv is primarily a news and entertainment medium, and should be approached in this context. And, because it joins sight with sound, it may not appear to be as easy to use for the novice. It may initially, appear too complex and too complicated to tackle. But, it can be used, and should be used whenever possible.

The basics still apply:

- know the station's regular program format (news, local shows, etc.)
- set up an appointment with the program or news director to discuss your activities
- have ideas in mind which have "audience appeal," are realistic in both content and timing and are within the capabilities of the station
- get all technical information you can from the individual station; how they prefer copy, slides, films, photographs, etc. prepared
- if a station agrees to participation in a local show or actual news coverage of an event--be prepared for it! Have props and visual aids ready. Have some activity in mind for a camera crew--(give example).

Keep in mind that local stations often offer their facilities for the production of local commercial spots. If they are willing, it may be possible for them to prepare and produce a spot for you which will meet their technical standards.

The spot can then be "dubbed" or reproduced for use by other stations. Whether they plan to charge professional rates, union fees only or sponsor the entire undertaking through the station's community affairs office must be established at the onset to avoid any future misunderstandings.

If you are writing copy for tv, remember your radio writing--for sound, for conversation. Now add sight. Your copy should be written to accompany certain visuals--usually slides, film, photographs or video tape. TV, as a visual medium must have accompanying visual material for exposure and use.

Another difference between radio and tv copy: time your copy slightly slower than your radio copy.

10 seconds -- 20 words
20 seconds -- 40 words
30 seconds -- 60 words
60 seconds -- 125 words

Make sure that your copy conforms to the visuals. If you use slides, number and identify them, indicating subject matter, order and time sequence.

Provide one slide or photograph for each 10-second spot; two for a 20-second spot, etc. Films or video tape can also be used. However, the acceptance of these will depend on the station and their quality and usefulness. Check with the program, news or public service director on any audio-visual materials you plan to use as illustrations for your message.

Slides are usually preferable to photographs and can be--should be--in color. (This is the opposite of newspaper photographs, and so is the fact that they should have a matte or dull finish. Glossy prints will reflect light, and often can't be distinguished when on the screen.)

All slides and photographs should be horizontal, with a ratio of four units of width to three units of height.

The subject of the slide--particularly a word slide--should be well centered. (The next time you are watching tv, notice how often a word slide will lose the first and last words of a long line of type or all of the bottom of the last line.)

Having slides produced for your spot need not be an expensive or overly complicated procedure. A professional photographer or graphics studio can help you if there is no one in your agency with this talent. And, the tv stations usually have an art department which can give you advice and assistance.

Remember to specify if you want your materials returned. Station's filing capacity is limited and out-dates materials are thrown away.

When you go on tv: many of the principles discussed in the radio appearance section obviously apply. You will have met with station personnel to discuss the interview or presentation. You will have given them advance written material--a biographical sketch, a fact sheet, etc. You will be preapred to arrive early enough to give the station staff amply time to prepare the set, the props, and you.

It would be a good idea to have props prepared in advance which you will discuss with the program director, or later the show's producer. Whatever these props may be--slides, films, actual products, a form of demonstration--they should be at the station in advance. That way they will be available for set-up and actual use as needed. Also, if time does not permit use of any or all of them, you can eliminate some, keeping the most important ones intact and in use.

Your personal appearance is naturally important, but looking natural will come across better than if you have just come from a salon. Women should wear natural, street (or day time) make-up. If you need a touch-up, the station staff will be there to correct it. Men, too, may need some make-up (a balding head, a heavy beard, etc.). Once again, leave this to the experts.

Your choice of clothes should be simple and casual. Wear suits or dresses of soft, medium colors. Avoid sharp contrasts like stark white or black as well as bright patterns and colors. Avoid too-short skirts or too-tight pants. The camera can be devastating! If you are to actually demonstrate something, you will be moving and need clothes which move gracefully and naturally. Keep your jewelry simple. Pearls and dull-finished metals won't reflect the lights as sparkling tones and highly polished jewelry will.

If you wear glasses, keep them on. Your eyes will react unnaturally if you are used to wearing them. Don't worry; the cameramen can make adjustments so that they won't glare.

If several members of your groups are to participate, why not have a mock run-through a day or two before the telecast. You can discuss your subject, allow a "part for each member," and generally rehearse. However, don't try to memorize a role or a speech. It will only make you nervous if you're trying to repeat "lines," and it will come across exactly that way over the air.

When you arrive at the studio--if not early, at least to the minute!--you will be met with what appears to be mad confusion: the lights; the sets; the tele-prompters; the milling of floor directors, assistance, and cameramen. These are technical aspects which are fascinating to watch, but need not concern you as part of the show. For you, this time will be devoted to preparing for it yourself--make-up, instructions from the technicians, last minute discussions of your presentation. If you have any questions, don't be afraid to ask! The director or the other technical aids are there to make the show work. It is everyday routine to them, yet completely foreign to you. Better to ask what you consider a dumb question at this time than to find--once on the air--that your question was a valid one.

You will certainly be nervous--everyone is! Relax your throat muscles by yawning or stretching. Even chewing gum may help if you don't forget to take it out before going on camera!

As with radio, try to imagine that you are merely talking to some close friends--on a subject that you are vitally concerned about and one which you know well. You are not talking to a camera, but to another person who is interested in what you have to say. While being interviewed: look, listen and speak to the person talking to you. If you do have a particular point you wish to make directly to the tv audience, look directly into the camera with a red light on. Do not try to watch yourself on the studio monitoring set. First of all, it will distract you. Second, it will distract the viewer because it will be noticeable. Be aware of any signs or signals given to you by the director or floor manager. You will be schooled in what to watch for--timing, movement, etc.--and what each hand signal means. Again, this is not something to worry about beforehand; they are there to help you and need only your cooperation.

After the show is over, you will be able to relax and wonder what all your fears were about--the first time is always the hardest! But after the show, remember to send thanks and any reactions received later on about the show. This is a definite assist to their public service and programming efforts, and it may give you continued coverage when you need and want it.

TV Spot #l shows how to prepare tv copy.

TELEVISION SPOT #1

Project SOAK (Summer Outdoor Activities for Kids)
P.O. Drawer PP
Santa Barbara, California 93109
965-3305

For Further Information, Contact: Carol Marks, 936-6673

FOR BROADCAST: Mon., Oct. 27 THRU SAT. NOV. 1, 1979

VIDEO	AUDIO
SLIDE #1 *(#) Scene of bored kid	There is a cure for the summertime blues! Project SOAK is here to keep you cool and comfortable this summer - we'll pick you up, take you to the beach, and teach you swimming in the bargain.
SLIDE #2 (#) Beach front activity SLIDE #3 (#) Close up of kids having fun SLIDE #4 (#) Swimming lesson SLIDE #5 (#) Same kid as SLIDE 1 enjoying himself SLIDE #6 (#) Word slide (Name, address, telephone #)	If you'd like some fun this summer, free of charge, are between 6-14 years old and live within the city limits of Santa Barbara, call Carol Marks at 936-6673. Take the dive, today.

*TV stations number slides according to their own system

**Copy for this announcement was written by the staff of the Department of Human Services, Santa Barbara, California.

PURPOSES OF A COUNCIL

Excerpts reprinted with permission from Monticello Public Schools, Monticello, Ark.

PURPOSES OF A COUNCIL

I. Formation of a Council

A. Ensure that there are adequate services and sufficient programs and services
B. Organize and coordinate a community-wide effort
  1. Involving the community
  2. Mobilizing resources
  3. Publicity
  4. Public statements to establish a constructive tone
  5. Lobbying/pressure group

II. Possible Services To Be Provided

A. Serving as a forum for exchange of ideas and information
B. Conflict resolution among various forces within the community (police, addicts, alienated youth, "do-gooders," etc.)
C. Collecting and disseminating information
D. Operating interagency management system
E. Review of plans and proposals
  1. Minimize duplication of effort
  2. Ensure that all necessary services are developed
  3. Serving as a "Seal of Approval" agency
  4. Serving as a drug abuse program review service for the state-level agency
F. Controlling allocation of funds

III. Program Operation

A. Activities of program
B. Funding and resources for program
C. Providing fiscal management
D. Structure of management
  1. Governing body
  2. Housing of program
  3. Operational management
  4. Staffing
E. Training and technical assistance

IV. Evaluation of Operational Programs

PEOPLE INVOLVEMENT

This article is reprinted, with permission, from Community Drug Abuse Prevention Program, Bureau of Narcotics and Dangerous Drugs, U.S. Department of Justice, 1970.

PEOPLE INVOLVEMENT

Yes, we want to help...what can we do?
(Parents, members of bar or judiciary, law enforcement officers, women's organizations, fraternal organization, union members, industrial executives, PTA members, college staff members or students, youth organizations, clergy or religious organizations, mental health association, hospital personnel, nurses, pharmacists, community health departments, medical societies, newspapers, radio and television.)

Any successful community program against drug abuse must involve the entire community. No single group or agency can provide for the wide range of problems involved. There is a role for every interested person and organization. The following suggestions are based on material developed by the state of New York for its community drug abuse programs and suggestions resulting from community programs in which the Bureau of Narcotics and Dangerous Drugs has participated.

WHAT CAN WE DO AS PARENTS

- Support local efforts to establish and fund resources for drug abuse counselling and treatment. Take an active part by offering your time in support of community drug abuse efforts.
- Maintain communication with your children. If you find it difficult to talk to them, at least let them know you are interested in their problems and anxious to listen.
- Learn as much as possible about the nature and symptoms of drug abuse.
- Know the danger signs of drug abuse.
- Learn where all sources of assistance exist.
- Seek counselling and professional help immediately when you are aware of the earliest signs of drug abuse. Encourage your close friends to do the same should the problem arise with their family.

WHAT CAN WE DO AS MEMBERS OF THE ORGANIZED BAR OR JUDICIARY

- Arrange for training seminars for members on the nature and effects of drug abuse.

- Promote and co-sponsor community drug abuse programs. Assist community programs executives in developing Federal, state, local and private funding resources.

- Identify developments that create alternative methods for handling drug cases. Present these options on a regular basis during meetings or seminars.

- Develop speakers bureau to handle program requirements on the legal aspects of drug abuse, penalties, citizen role, etc., make this information available to public education seminars and meetings wherever possible.

- Make a specific effort to organize youth involvement programs through which you can establish liaison that will help establish a line of communication between the youthful community and the law.

- Assist youth groups with their effort at organizing youth oriented and youth administered prevention programs.

- Familiarize members with available counselling and treatment resources. Set up visits to treatment centers and urge attendance by members.

- Create legal counselling resource for families or young people with drug related problems. Possibly offer such service on a regular basis as part of an organized community drug abuse center as a public service.

WHAT CAN WE DO AS LAW ENFORCEMENT OFFICIALS (POLICE & DISTRICT ATTORNEYS)

- Promote and co-sponsor local prevention programs.

- Provide speakers for local community organizations.

- Conduct regularly scheduled discussions (rap) sessions with youths and youth groups.

- Establish an active and on-going liaison with school authorities.

- Inform community of the role and discretion of the police officers.

- Develop mutually agreed upon guidelines for teachers, counsellors and school administrators regarding suspected drug abuse, contraband disposal.

- Establish juvenile aid bureau and encourage participation and support by community.
- Arrange for establishment and specialized training of narcotics squads for use in high drug traffic areas.
- Create liaison with other Regional law enforcement forces to establish a pool of information on distribution systems and supply networks.
- Encourage specialized training on the nature of the drug problem for all officers on the force.

WHAT CAN WE DO AS MEMBERS OF WOMEN'S ORGANIZATIONS

- Through voter's league, help to secure legislation to solve the drug problem.
- Conduct training programs for members on the problems of drug abuse.
- Offer clerical and professional support to the organized community drug abuse program.
- Assist with development of funding resources for community programs facilities, supplies, etc.

WHAT CAN WE DO AS MEMBERS OF FRATERNAL ORGANIZATION, VETERANS ORGANIZATIONS, ETC.

- Encourage participation in training sessions by key leaders.
- Organize series of orientation meetings for all members using key leaders as lecturers.
- Recruit volunteers to support the community drug abuse program.
- Assist with funding campaigns to support community drug abuse program.

WHAT CAN WE DO AS UNION MEMBERS

- Sponsor educational programs for members.
- Establish in plant anti-drug campaigns.
- Provide financial and personnel assistance to community drug abuse programs.

- Sponsor evening programs for employees of small businesses.

WHAT CAN WE DO IF WE ARE INDUSTRIAL EXECUTIVES

- Create training programs for ex-addicts.
- Hire ex-addicts who meet screening requirements.
- Establish ease of liaison between employees and sources of counsel, assistance and education in drug abuse.
- Take advantage of government funding sources for fiscal support of ex-addict training and hiring programs.
- Provide funds to support local drug abuse programs.
- Encourage part-time support of community effort against drug abuse by employees.

WHAT CAN WE DO AS PTA MEMBERS OR TEACHERS

- Develop a cooperative program with the school in adult drug education.
- Serve schools implementing drug education programs through advisory services, purchase of special films, publications and endorsement and support of policies of school program.
- Serve as active liaison between school--home--community in getting total support for school policy. Interpret and explain total problem as widely as possible.
- Establish a program aimed at eradicating the position of hypocrisy in adults who innocently or ignorantly condone many more subtle drug abuse practices in their own generation than is commonly recognized.
- Set up meetings involving youth participation. Give youth an active role in your part of community service. Establish identification with local youth as a group that is willing to respond to problems facing them.

WHAT CAN WE DO AS HIGH SCHOOL & COLLEGE FACULTY OR STUDENTS

- Organize a drug abuse committee composed of faculty, students, and administration.
- Establish counselling services thru college health department

or medical service.

- Establish a speakers bureau composed of specialists both on and off campus to respond to college wide requirements ranging from rap groups to formal seminars on a continuing basis.
- Organize workshop training sessions for student, faculty and administration leaders.
- Establish an emergency resource such as a 24-hour telephone contact or hotline for drug abuse emergency victims.
- Share services with community sponsored drug abuse program.

WHAT CAN WE DO AS MEMBERS OF YOUTH ORGANIZATIONS

- Have specific segments of your total program set aside for discussion of the drug abuse problem.
- Schedule films, guest speakers, etc.
- Combine with other groups to provide support where needed in community drug abuse prevention campaigns or programs.
- Conduct exhibit and display projects.
- Organize a dramatic group and a presentation on drug abuse that can be made available to other organizations.
- Organize (under professional guidance) a group of high school youths to conduct rap sessions with elementary school youngsters.
- Parents and group leadership training sessions should be established.
- Have father-son dinners with role models such as prominent athletes as speakers with drug prevention as part of their presentation.
- Establish an "information anonymous" center to which concerned young people can direct information regarding drug abuse of which they become aware.

WHAT CAN WE DO AS MEMBERS OF THE CLERGY OR RELIGIOUS ORGANIZATIONS

- Conduct church sponsored drug abuse discussion groups.
- Develop sermons on drug abuse.

- Provide church sponsored pastoral counselling service.
- Have adult church groups hold meetings specifically designed to discuss adult drug abuse and its relationship to drug abuse by youth.
- Organize a teen center, coffee house or other social center.
- Establish a regular drug abuse information column in the church bulletin.
- Have church groups conduct fund raising projects to support community programs.
- Establish an information center on drug counselling and treatment.
- Conduct training seminars for clergy and lay leaders in the community.

WHAT CAN WE DO AS MEMBERS OF THE MENTAL HEALTH ASSOCIATION

- Stimulate development of community counselling and treatment resources.
- Establish drug information seminars for staff membership of associations.
- Conduct statistical study and record nature and extent of drug abuse problem in your community.
- Organize a speakers bureau.

WHAT CAN WE DO AS HOSPITAL PERSONNEL

- Train all medical and para medical staff and establish emergency treatment center for drug abuse victims.
- Set up referral system for post emergency care.
- Provide speakers and general support to community drug abuse education program.
- Provide consultation to community groups on effects and implications of drug abuse.
- Assist schools, mental health boards and community centers with developments of early identification and referral program.

- Develop treatment programs within the hospital.
- Provide voluntary services to community sponsored projects.
- Train hospital medical emergency personnel such as ambulance staff in emergency narcotics techniques, offer training to commercial ambulance personnel as well.

WHAT CAN WE DO? NEWSPAPERS, RADIO AND TELEVISION

- Provide coverage of news related to drug programs (treatment, education, prevention) over and above coverage of arrests, deaths, etc.
- Conduct programs--regularly scheduled and specials--with major emphasis on drug education/prevention; i.e., talk shows, telephone call-in programs, etc.
- Involvement in a major "spot" or "ad" campaign.
- Run a series of articles on drug programs, problems, resources, education/prevention, etc.
- Conduct training sessions for own staff to develop a better understanding of the problems related to drug abuse, drug substances, etc.
- Provide editorial commentary urging public's understanding and involvement in abating the problem.
- Be a resource for information on drugs as solicited by the listening public as a public service.

WHAT CAN WE DO AS NURSES

- Assist in developing the role of the school nurse in areas of drug identification, prevention and treatment.
- Encourage professional nurses associations to take active part in support of community prevention and treatment programs.
- Develop a speakers resource to support lectures and seminars on drug addiction for students, faculty and parents.
- Encourage inclusion of courses in drug abuse in the nurse training curriculum.
- Use public health nurse as a resource for gathering incidences

and prevalent information on addiction. Also could become treatment referral person.

Offer free professional services to community sponsored treatment and prevention centers.

WHAT CAN WE DO AS PHARMACISTS

- Sponsor drug abuse education courses for members of your profession.
- Make your pharmacy a community drug abuse information center.
- Actively encourage support of Federal drug control compliance recommendations.
- Establish a community-wide abuse vigilance capacity through which illicit abuse may be revealed.

WHAT CAN WE DO AS MEMBERS OF COMMUNITY HEALTH DEPTS.

- Provide staff assistance to community sponsored drug abuse projects.
- Train staff in drug abuse problems.
- Collect and make available to the public such resources as printed information, films and speakers.
- Establish a roster of diagnostic and treatment resources.
- When possible provide treatment facility.
- Encourage establishment of treatment and diagnostic capability by other community professional groups.
- Establish and train a corps of personnel equipped to identify drug abuse, and advising families regarding available treatment, counselling and diagnostic services.

WHAT CAN WE DO AS MEMBERS OF MEDICAL SOCIETIES

- Sponsor and support education courses in drug abuse for physicians.
- Maintain a speakers bureau to support community efforts.

- Prepare papers, booklets, sound tapes, etc. for distribution to "medical community."

- Encourage society membership to engage in greater personal participation in the treatment programs for addicts and to develop the facility to respond to medical emergencies related to drug abuse.

- Offer consultative services to schools, colleges, community groups and other non-medical entities involved in the drug abuse problem.

SOURCES OF COMMUNITY SUPPORT

Reprinted with permission from Effective Coordination of Drug Abuse Programs: A Guide to Community Action, Center for Studies of Narcotic and Drug Abuse, National Institute on Drug Abuse, 1972.

SOURCES OF COMMUNITY SUPPORT

1. *Volunteers* of all kinds, from all sectors of the community, who can provide skills, manpower, funds, and materials.

2. *Medical groups, practitioners, health and mental health workers*, especially those not yet active whose clientele is most likely to include drug abusers. This includes medical and nursing societies, osteopathic associations, mental health associations, groups such as the Medical Committee for Human Rights, and the like.

3. *Lawyers, accountants and other professionals* who can provide a variety of skills, from assisting in the preparation of new legislation to developing bookkeeping systems. Increasingly, law firms are providing free *(pro bono publico)* services to agencies acting in the public interest.

4. *Local educational institutions* which might offer training to staffs of treatment and prevention programs, provide assistance in conducting needs analyses, evaluate programs, and otherwise offer program support. Students often receive credit for working with community groups and are especially useful for such things as data collection.

5. *Public and private schools* which can offer responsible and sensible education programs, improve their procedures for handling troubled students and link into efforts to provide productive alternatives for the youth of the community.

6. *Military organizations, bases and installations*, including hospitals, on-post groups and veterans groups who can provide or support service programs of various kinds.

7. *Mayors, city councilmen, and other elected public officials* who can mobilize community support, moderate conflicts, provide support and sponsorship for controversial programs and the like.

8. *The media*, especially TV, to encourage use of programs developed elsewhere, to encourage development of programs tailored to the community's own needs, and to ensure responsible coverage of the situation.

9. *Social and volunteer service organizations*, especially such groups as the Optimists and Kiwanis who encourage their chapters to become involved in drug abuse efforts. This also includes women's clubs, volunteer service bureaus, the Red Cross, etc.

10. *The welfare department*, where an effort might be made to obtain rulings permitting addicts to receive welfare benefits which could, for example, virtually support the activities of a therapeutic community.

11. *Other local government agencies*, such as housing, recreation, child care, health, transportation, sanitation, environmental improvement, etc., which can provide a great variety of services, programs and support.

12. *Religious organizations*, especially to encourage them to provide for abusers in existing counseling efforts.

13. *The business community and unions*, who can assist in organizing resources, open up jobs for ex-abusers, and supply resources for different aspects of the program.

14. *Employment and vocational rehabilitation agencies*, who can offer job training, supply follow-up supportive services and the like.

15. *Community organizations*, especially in areas of high drug abuse incidence, to assist in developing local-level programs (especially community action or anti-poverty agencies or neighborhood centers in model cities agencies). This includes civil rights groups, welfare and tenants rights organizations, ethnic and racial groups and the like.

16. *Youth organizations*, especially those involving counter-culture youth, and other members of "at risk" groups. These can include ecology groups, political education groups, "underground" media, etc.

17. *Organized self-help groups* of ex-addicts and drug abusers who can generally contribute in a major way to prevention efforts and for the development of viable alternatives to drug abuse. They also can be sources of excellent program personnel.

18. *Clients of drug treatment programs*, many of whom are eager to help increase the level and effectiveness of local efforts, by serving as speakers, program consultants, youth counselors, etc.

19. *Other related efforts* such as programs for alcoholics, formal mental patients, and the like.

20. *VISTA Volunteers*, who can be either from within or outside the community with which they work, are often available to work with programs that primarily serve low-income clientele. (Details can be obtained from ACTION, Washington, D. C.).

MODULE VIII

MODULE VIII: NETWORKING AND RESOURCE BUILDING **TIME:** 3 HOURS

GOALS

- Provide participants with a conceptual understanding of "networking"
- Enable them to identify potential community resources
- Assist them to formulate an action plan to develop a school-based prevention program in their own community.

OBJECTIVES:

At the end of this module, participants will be able to:

- Define and explain the concepts of networking
- Identify six community agencies with whom they could develop a network for prevention
- Identify personal, organizational, and community resources for prevention programs
- Identify basic resource materials and sources of technical assistance for prevention programs.
- Define and explain the concepts of process outcome and impact evaluation as defined in the NPERN guidelines.

MATERIALS:

- Newsprint
- Magic Markers
- "Broken Squares" Game
- Participant action planning worksheets (from other modules)
- Reference materials

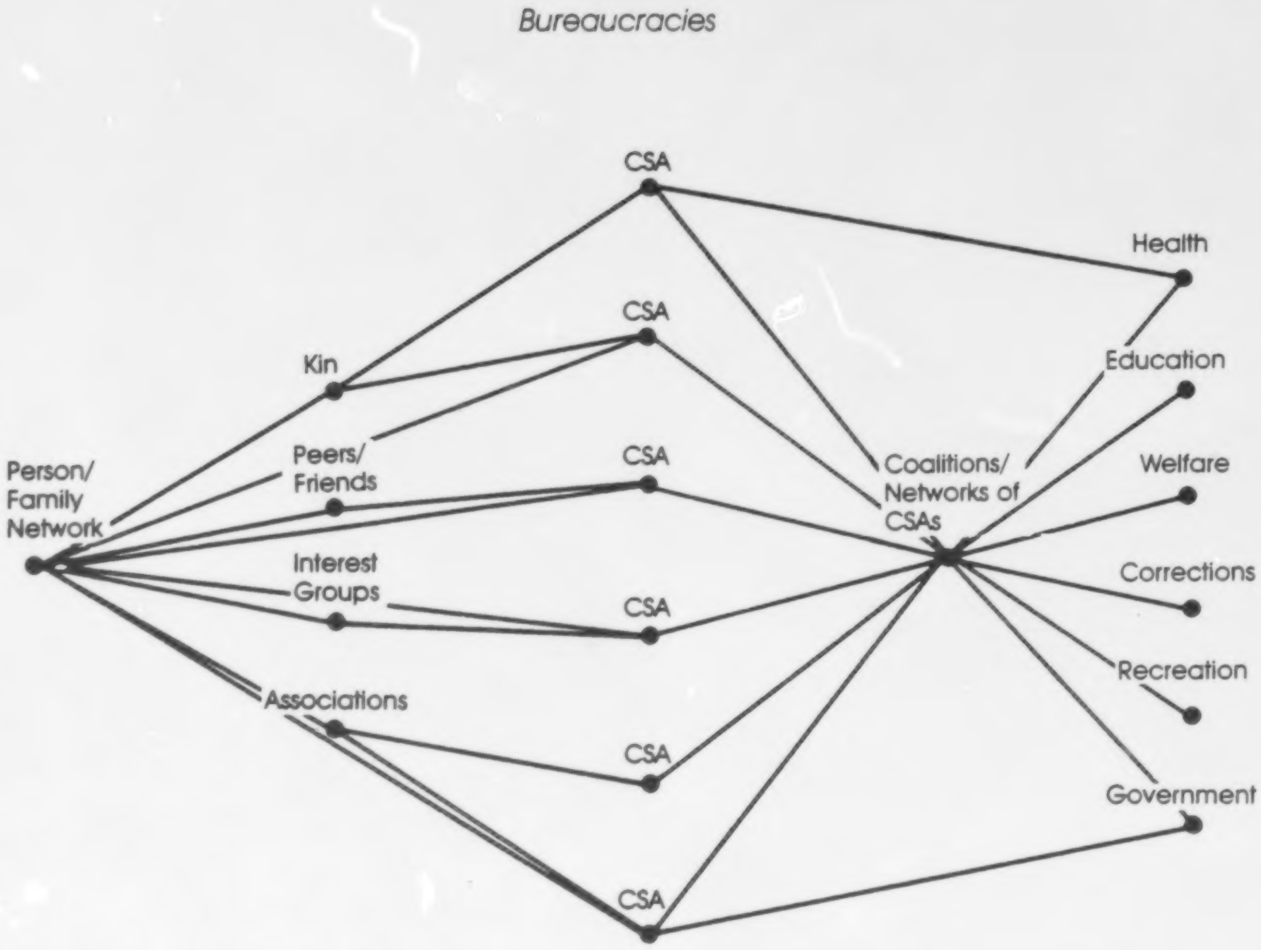
    - "Networks: A Key to Person-Community Development," by Anne Dosher, Ph.D.

    - "Make a Network" worksheets

    - "A Basic Prevention Library"

MODULE VIII OVERVIEW

EXERCISE	TIME	METHODOLOGY
1. NETWORKING	30 MINUTES	LECTURE/DISCUSSION
2. APPLY NETWORKING TO DEVELOPING PREVENTION PROGRAMS	30 MINUTES	SMALL-GROUP EXERCISE
3. BROKEN SQUARES GAME	35 MINUTES	INDIVIDUAL EXERCISE
4. TRAINER WRAP-UP	10 MINUTES	LECTURE
5. PERSONALIZING THE THEORY	15 MINUTES	INDIVIDUAL EXERCISE
6. BUILDING RESOURCES	20 MINUTES	LECTURE/DISCUSSION
7. PLUSES AND WISHES	15 MINUTES	INDIVIDUAL EXERCISE
8. FINDING RESOURCES	20 MINUTES	LECTURE/DISCUSSION
9. AND A GOOD WORD ABOUT EVALUATION	30 MINUTES	LECTURE/DISCUSSION


Bureaucracies
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Friends
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CSAs
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Corrections
CSA
Recreation
Associations
CSA
Government
CSA

Interorganizational Networks

CSA = community service agency

MAKE A NETWORK

1. List 6 possible members of a network to assist in achieving your program goals.

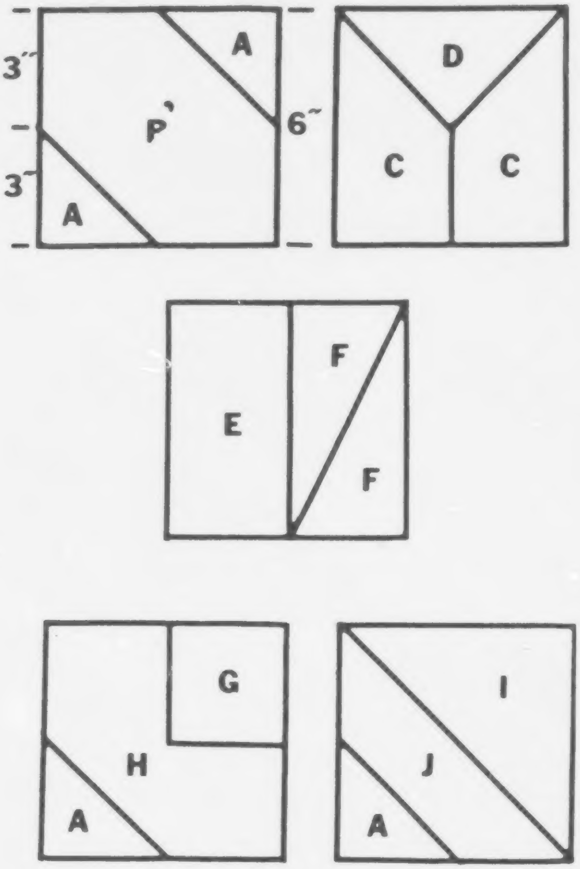
    1. ______________________________
    2. ______________________________
    3. ______________________________
    4. ______________________________
    5. ______________________________
    6. ______________________________

2. Draw a diagram of how you think the elements of your network might cooperate.

PLUSES AND WISHES

WHAT I HAVE	WHAT I WANT
WHAT MY ORGANIZATION HAS	WHAT I'D LIKE MY ORGANIZATION TO HAVE
WHAT MY COMMUNITY HAS	WHAT I'D LIKE MY COMMUNITY TO HAVE

BROKEN SQUARES GAME
MATERIALS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A BASIC PREVENTION LIBRARY

Resource Publications

Ardell, Donald B. High Level Wellness: An Alternative To Doctors, Drugs and Disease. Emmaus, Pa.: Rodale Press, 1977.

Center for Human Services. Prevention Needs Assessment Workbook. Rockville, Md.: National Institute on Drug Abuse, Prevention Branch, 1979.

Center for Human Services. Prevention Planning Workbook. Rockville, Md.: National Institute on Drug Abuse, Prevention Branch, 1978.

Center for Multicultural Awareness. Administered by Development Associates, Inc. Multicultural Drug Abuse Prevention (Booklet 1). Rockville, Md.: National Institute on Drug Abuse, 1979.

Center for Multicultural Awareness. Administered by Development Associates, Inc. Needs Assessment (Booklet 2). Rockville, Md.: National Institute on Drug Abuse, 1979.

Center for Multicultural Awareness. Administered by Development Associates, Inc. Multicultural Strategies (Booklet 3). Rockville, Md.: National Institute on Drug Abuse, 1979.

Center for Multicultural Awareness. Administered by Development Associates, Inc. Funding Strategies (Booklet 5) Rockville, Md.: National Institute on Drug Abuse, 1979.

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National Center for Alcohol Education. Decisions and Drinking: An Ounce of Prevention. (DHEW Publication No. ADM-77-454). Rockville, Md.: National Institute on Alcohol Abuse and Alcoholism, 1977.

National Center for Alcohol Education. Decisions and Drinking: The Power of Positive Parenting. (DHEW Publication No. ADM-77-453). Rockville, Md.: National Institute on Alcohol Abuse and Alcoholism, 1977.

National Center for Alcohol Education. Decisions and Drinking: Reflections in a Glass. (DHEW Publication No. ADM-77-452). Rockville, Md.: National Institute on Alcohol Abuse and Alcoholism, 1977.

National Clearinghouse for Alcohol Information. *Alcoholism Prevention: Guide To Resources and References.* (DHEW Publication on No. ADM-79-886). *and References*. Rockville, Md.: National Institute on Alcohol Abuse and Alcoholism, 1979.

National Institute on Drug Abuse, Prevention Branch. *Primary Prevention in Drug Abuse*. (DHEW Publication No. ADM76350). Washington, D.C.: U.S. Government Printing Office, 1977.

National Institute on Drug Abuse *Research Monograph Series*. Rockville, Md.: National Institute on Drug Abuse.

National Prevention Evaluation Resource Network. *Prevention Evaluation Guidelines.* In publication: Rockville, Md.: National Institute on Drug Abuse, 1979.

Nowlis, Helen H. *Drugs Demystified*. Paris: UNESCO Press, 1975.

Public Health Service, Office of the Assistant Secretary for Health and Surgeon General. *Healthy People: The Surgeon General's Report on Health Promotion and Disease Prevention*. (DHEW Publication No. 7955071). Washington, D.C.: U. S. Government Printing Office, 1979.

Pacific Institute for Research and Evaluation: Pyramid Project. *Balancing Head and Heart: Sensible Ideas for the Prevention of Drug and Alcohol Abuse*. Lafayette, Calif.: Prevention Materials Press, 1975.

Pacific Institute for Research and Evaluation. Pyramid Project. *Teaching Tools for Primary Prevention: A Guide To Calssroom Curricula*. Lafayette, Calif.: Prevention Materials Press, 1979.

Resnik, Henry S. *It Starts with People: Experiences in Drug Abuse Prevention*. (DHEW Publication No. ADM-79-590). Rockville, Md.: National Institute on Drug Abuse, 1978.

Audiovisual Resources

National Institute of Mental Health, Drug Abuse Film Collection. *The Social Seminar Series*. Washington, D.C.: National Audiovisual Center (GSA), 1971.

Local Resources

State plan--available from the State Prevention Coordinator in the Single State Agency

State Media Directory--available from the telephone company business office

Local directory of Community agencies--available through United Way

Statewide substance abuse program directory--available through the Single State Agency

Technical Assistance Sources

PYRAMID Project (West) 3746 MH. Diablo Blvd. Suite 200, Layfayette, Calif.
415-284-5300

PYRAMID Project (East) 7101 Wisconsin Avenue, Suite 1006, Bethesda, Md.
301-654-1194

Center for Multicultural Awareness, 2924 Columbia Pike, Arlington, VA. 22204
703-979-0100

National Drug Abuse Center, 5530 Wisconsin Avenue, Chevy Chase, Md. 20015
301-654-3582

Regional Support Centers

Single State Agencies

Professional Associations

National Association of Prevention Professionals, 176 W. Adams Street, Chicago, Illinois, 312-782-3479

National Association of State Alcohol and Drug ABuse Directors, 1612 K Street, NW. Washington, D.C. 202-659-7632

NOTE: For information on minority coalitions/associations, contact the Center for Multicultural Awareness

Newsletters

Training the Human Resources--published by the National Institute on Drug Abuse, Manpower and Training Branch, Rockville, Md. 20857

The Prevention Resource Bulletin--published by PYRAMID, Lafayette, Calif., under contract to the National Institute on Drug Abuse, Prevention Branch.

NETWORKS:

A KEY TO PERSON-COMMUNITY DEVELOPMENT

Paper by Anne W. Dosher, Ph.D., Community Consultant; presented to Office of Youth Development, Denver Hearings, February 17, 1977, Department of Health and Human Services.

> My starting point is the fundamental initial fact that each of us is perforce linked by all the material, organic and psychic strands of his being to all that surrounds him. Not only is he caught up in a network, he is carried along, too, by a stream. All around us, in whatever direction we look, there are both links and currents. We are all interconnected elements of one and the same curve that extends ahead of and reaches behind us.
>
> Pierre Theilhard de Chardin
> The Prayer of the Universe

The idea of network and networking is basic to those of us who have been working in communities and movements over the decades; for organizing is the process of bringing together various elements in order to develop a whole, a combination of nodes, (people, groups, organizations, systems) for a common purpose. We develop networks as ongoing organizations and carefully tend the three variables of:

a) nodes of the network (people, organizations, systems)

b) information flow (feelings, facts, data)

c) linkages (pathways for information).

We are all connected in networks of many kinds: family, peer, neighbors, workers, interest groups, associations, organizations. Some of these networks are grounded in our local community; others are placed in our memory and mind and are part of our non-spatial community.

Person-Family Networks: Every person today is embedded in a network of aligned, patterned family relationships. The pathways linking the persons may provide strong or weak bonds; the information flow may be static, toxic or healing; not every person can see or use all the possibilities. A net, however, is strong and flexible: teach the person to turn effectively on the net by reaching to the next person(s) and call along the pathways, and the whole actively becomes more than the sum of the parts; relationships change; healing and community occur.

One way to assist a person to make visible their network is to have them draw the total relational field of which they are a part: this usually has both space and time dimensions. A personal example follows (Figure I). A family network facilitator would attempt to bring the net together in order to develop the support system if a member of the net was in crisis. (Speck, Attneave: 1973).

Organizational network: When the person and family require care from the community, they reach out through the net of kin, peers, interest gorups and associations, into the community itself. Frequently, the small, indigenous community-based program is activating the net through neighborhood outreach programs. Person meets person and a connection is made. The program organizer then turns on the net of surrogate care which is needed to support the person and family in its search for problem solving skills, resources and community. Seldom are the resources contained within one program, and the organizer turns to the human service networks.

Interorganizational networks: The practice of creating networks followed the organic development of the small, indigenous, community-based agencies, clinics, hotlines and runaway houses during the sixties. Programs, faced with the requirement to grow in order to provide services and interact with the complex major systems of an unstable society in order to acquire resources, had to "clone" locally and find connections with others. Across communities, regions, states and the society, a system began developing which could maintain a separate reality and consensus and gain expertise in the face of growth and complexity.

Human service networks: These interorganizational, intersystem networks developed as ongoing organizations of people working together in a system of service that began to provide pathways for information about service technologies, services, resources, coordination and support systems. As networks, they are ongoing, process-oriented, member-supportive, decentralized learning systems, providing for: broad membership, continuous information flow, idea exchange, feedback, resource sharing and development, and boundary exchange with other networks. The list is not inclusive. A County example would be the Community Congress of San Diego, a network which I co-organized and for which I serve as Core Consultant. Other examples are: National Network of Runaway and Youth Services, National Council of Free Clinics, and the developing mutual support and self-help networks, such as: Parents Without Partners, Widow to Widow, Live Every Day. An interorganizational example follows (Figure 2).

Purpose, function and structure of networks

Purpose (the "why" of the network) is to develop a mediating mechanism which brings healing intervention between persons, families, groups, organizations, community and society, and learning which produces resources, capacity-building, ideas, innovations, diffusion systems and transcendence.

Functions (the activites of the network) are:

a) communication linkages and information channels for exchange of needs/resources

b) participant support systems and resource sharing

c) means for coordination, cooperation, collaboration, person/program actualization, training and capacity-building

d) means for collection action

Structure: (Figure 3 below)

A network is structure as above, with nodes, pathways and information. Roles essential to the design, creation, negotiation and management of networks include: systems negotiator, underground manager, manoeuverer, broker, manager, facilitator, (Schon; 1971). Skills include: interpersonal communications, group dynamics, organization development and management, negotiation, mobilization, planning, change process conceptualization.

Relationships: The relationships between elements and systems, history and values, and organizational memory and funding are key issues for a network.

Elements and system:

> A network is a set of elements related to one another through multiple interconnections. The metaphor of the net suggests a special kind of interconnectedness, one dependent on nodes in which several connecting strands meet. There is the suggestion both of each element being connected to every other, and of elements connecting through one another rather than to each other through a center.....
>
> Donald Schon
> Beyond the Stable State

As Schon's description clearly states, one value of a network is its ability to support a practice which places value on person-centeredness and small units, valuing, problem solving and systems approaches. Due to the connections at the "node," the small unit may be valued, and due to rapid communication information flow, the whole may be comprehended.

History and values:

A network without a memory system (history, valuing, timing) cannot exist or plan to continue. In an inter-generational system (18 months to 2 years is the average "life" of most staff), the need to maintain histories and clear values as the foundation of an intergrated network becomes evident. Every person must become a historian and every organization identify the function in order to develop and maintain organizational and system memory. Values must be regularly clarified and confirmed if the purpose is to be carried out and congruence maintained between stated, structured and lived values. The flow of HISTORY-VALUES-PURPOSE-GOALS-OBJECTIVES-PROGRAM ACTIVITIES-IMPLEMENTATION/TIMELINE-EVALUATION-NEW IMAGE-PROACTIVE PLAN must be conceptualized as the cycle process continues.

Negotiation across the time worlds of clients, direct service, indirect service, community systems, and national guidance systems must occur: indeed, network members must know the differences if effecting planning is to occur.

As a result, training methods have been introduced into the networks: values processing, time worlds processing, network organizing.

Memory and funding:

The short term (single year) funding practice of societal systems does not nurture a network. Rather, the practice destroys key foundations of history, values, time investments, structures, and functions. The community nurturing system feeds in short, jerky, inadequate and shifting patterns leading to frustrations, pain, despair, and the outcry of persons, organizations and communities. The practice is one which should be reformed by public policy and revised in that most formal of all memory systems: Legislation and the Legislature.

Ten Guidelines for Networks: learning systems, support systems, and creators of the new. (This can be adopted for each level of social organization: person, family/group, organization, interorganizational field system).

1. DEVELOP A STATEMENT OF PURPOSE which is broad and generalizable in order to encompass many shades of value orientations under its rubric; for example:

> The Community Congress of San Diego has as its primary purpose the enhancement of community functioning at all levels of human life including those of individuals, groups, organizations, and the total San Diego community.

2. KNOW THYSELF. Know that the reason you are developing a network is to create a new reality which is closer to your shared vision of what should and could be. Cherish your vision, but articulate it pragmatically in long and short range goals, made operational by procedural objectives, and measurable outcomes.

3. FACE POWER ISSUES openly, squarely, and in timely fashion both internally in the network, and externally in the environment. A network of any dimension, from family to group to organization to major system, must be based on shared power and responsibility. This entails an extremely interactive model of relationship, in which interdependence is the value. The shared credit that comes with shared power is imparative if the cohesiveness so essential for viable network functioning is to be maintained.

4. GIVE PRIORITY TO INFORMATION PROCESSING. Successful interpersonal, group, and interorganizational communications are your energy sources. Cultivate, streamline, and maintain these flows through the channels of the networks.

5. IDENTIFY, TRAIN, AND NURTURE LEADERS at every node throughout the network. Continuously recruit persons from the interpersonal network, the staffs, and boards of agencies, and community members. The more conscious, motivated, and developed the persons who make up the network, the more diverse the roles and statuses represented in the network, the more powerful, cohesive, viable, and flexible the network will be.

6. IDENTIFY "BOUNDARY PERSONS." Every network needs people with the following skills: interpersonal communications, group dynamics, organization development and management, systems negotiation, mobilization, planning, change process conceptualization. Set up co-learning sessions and develop the depth of skills across the network.

7. CONCEPTUALIZE YOUR NETWORK AS A LEARNING SYSTEM: a process open to new learners, cherishing of the long-time learners, open to continous feedback from members and communities, able to capture and rationalize issues,

and flexible in order to bring ideas, innovations, and new models to bear on problems and issues of the moment. A network exists to create new knowledge.

8. STRESS MANAGEMENT, ACCOUNTABILITY, RESPONSIBILITY. Bad management, lack of accountability and irresponsible action will mar your credibility internally in the network, and externally in traditional systems. The network, while maintaining creativity, innovation, and rapid response, must be purer than the driven snow.

9. EVALUATE STRINGENTLY. Invent the models for appropriate evaluation of your work. As creators and innovators, you alone know best how to articulate, measure, and value your actions or projects in the world. Keep records in detailed and rational form against your own defensible models.

If you do not, the traditional system, or your funding sources will estimate your worth against inappropriate measures. Concern for the valuing process equals survival and provides a basis for proactive planning.

10. CELEBRATE AND TREASURE THE PAYOFFS provided by your network efforts: new relationships, a sense of community among dedicated fellow members, cooperation instead of competition, economics of love, new setting development, information processing, policy changes...new meanings for ways of being in the world.

Visions for the Future.

What, you may ask, is new about any of this? The "new" comes, first, from the necessity for every person to be trained today in the art of selfconscious networking in order to learn new behavior leading to systematized, more effective interactions with social networks in private, communal, and societal life.

Second, when a person acts with others to create community (which represents common values), then the qualities though which both that person and that community develops are identical: freedom, power, and community. The ethics of the person are characterized by discipline, responsibility, and obligation, and motivated by personal choice which leads to participation and praxis. In turn, the developed community grounds personal action, self fulfillment, individual opportunity, and styles of life through the provision of institutional opportunity structures characterized by: Openness, ordered and accessible, richness, sufficient and diverse; person centeredness, authentic and integrating; and freedom, flexible, voluntary and controllable. (Haworth: 1966).

Third, when societal guidance systems such as the Office of Youth Development develop and support community network mechanisms which mediate between the person and society, that national system should also always refer to the first and basic moral criteria which could lead the system to allocate nurturing vs depriving, loving vs fearful resources--in intent, purpose, or method.

What is very old, but which must be made new again in the consciousness of all persons, is the knowledge that, in order to develop young persons subjectively through employment, socialization, education, training, or treatment, we must provide an objective reality which grounds the person in the real community (for example, provides roles, statuses, skills, jobs, resources), and confirms the person in the society. Networks are keys which can help accomplish this goal: the networks of persons, groups, organizations, communities, and systems; and, the networks in our minds and visions.

PREVENTION EVALUATION GUIDELINES

NATIONAL PREVENTION EVALUATION RESOURCE NETWORK

Prepared by

National Institute on Drug Abuse

Reprinted from the National Prevention Evaluation Guidelines, National Institute on Drug Abuse, August, 1979.

CHAPTER 2: MODEL FOR EVALUATION

INTRODUCTION

NIDA's Prevention Branch as developed an evaluation research model that is applicable to any of the four drug abuse prevention modalities (information, education, alternatives, and early intervention) and any of the five primary targets (individuals, peers, families, and the school, and other significant social institutions). The model, illustrated in Figure 2, features three levels of evaluation: Process, outcome and impact.

Process evaluation refers to an assessment of a prevention program that includes identification of the client population, a description of the services delivered, the utilization of resources for the programs, and the qualifications and experiences of the personnel participating in them. Process evaluation attempts to capture in "still frame" the characteristics of an operational, ongoing prevention program.

Outcome evaluation is concerned with measuring the effect of a project on the people participating in it. This includes youths, parents and families, couselors, and youth workers, teachers, and so on. Outcome evaluation attempts to answer the question: "What has this program produced relevant to the lifestyles, attitudes, and behaviors of those individuals it is attempting to reach?" In essence, outcome evaluation tries to determine if a prevention project has met its own objectives.

Impact evaluation explores the aggregate effect of prevention programs on the community as a whole. The community may be defined as a school system, county, city, state, region of the country, or the nation. The purpose of impact evaluation is to gauge the additive effects of numerous drug abuse prevention programs operating within a geographic boundary, or of an individual drug abuse prevention program running an extended period of time, say, five years.

The model presented in this chapter complements NIDA's prevention evaluative research model. It offers a conceptual framework for presenting evaluation issues, strategies, and methodologies throughout the Guidelines. It also serves to illustrate an "ideal" process by which prevention program evaluations may be conducted.

This model focuses on two kinds of issues pertinent to evaluation, those which (1) are necessary for effective evaluation of drug abuse prevention and other human service programs, and (2) reflect more broadly on the current thought regarding procedures and strategies that will enhance the quality of evaluation research.

Figure 2. DRUG ABUSE PREVENTION EVALUATIVE RESEARCH MODEL

TYPE OF EVALUATION	PROCESS →	OUTCOME →	IMPACT
LEVEL OF EVALUATION	PREVENTION PROGRAM EFFECTS		AGGREGATE OR CUMULATIVE EFFECTS AT THE COMMUNITY LEVEL
POTENTIAL INDICATORS OF EFFECTIVENESS	DESCRIPTION OF TARGET AUDIENCE/RECIPIENTS OF SERVICE PREVENTION SERVICES DELIVERED STAFF ACTIVITIES PLANNED/PERFORMED FINANCING RESOURCES UTILIZED	CHANGES IN DRUG-RELATED: - PERCEPTIONS - ATTITUDES - KNOWLEDGE - ACTIONS: DRUG USE TRUANCY SCHOOL ACHIEVEMENT INVOLVEMENT IN COMMUNITY ACTIVITIES	CHANGES IN: - PREVALENCE AND INCIDENCE OF DRUG USE - DRUG-RELATED MORTALITY/MORBIDITY - INSTITUTIONAL POLICY/PROGRAMS - YOUTH/PARENT INVOLVEMENT IN COMMUNITY - ACCIDENT RATES
POTENTIAL PREVENTION EVALUATIVE APPROACHES	EXAMPLES: THE COOPER MODEL FOR PROCESS EVALUATION NIDA-CONSAD MODEL NIDA-COST ACCOUNTABILITY MODEL QUALITY ASSURANCE ASSESSMENT	EXAMPLES: EXPERIMENTAL PARADIGMS QUASI-EXPERIMENTAL DESIGNS IPSATIVE DESIGNS E.G., GOAL ATTAINMENT SCALING	EXAMPLES: EPIDEMIOLOGIC STUDIES INCIDENCE AND PREVALENCE STUDIES DRUG-RELATED SCHOOL SURVEYS COST-BENEFIT ANALYSIS

NEED FOR A MODEL

Numerous surveys of evaluations in human service areas, including drug abuse prevention, consistently find that:

- Few evaluations are performed in response to previously stated decision-making requirements.
- Most evaluations suffer from serious methodological deficiencies.
- Most evaluations focus on outcomes, with little or no information on program process or on impact within the community.

There are three concepts critical to the effectiveness of drug abuse prevention evaluations. First, the field of evaluation research has developed a wide range of methods and strategies, building on the many scientific disciplines that have contributed to the evaluation of human services, namely, psychology, sociology, anthropology, political science, statistics, operations research, and computer science. Evaluators working in the field of drug abuse prevention need to be aware of this body of knowledge and its appropriate application.

Second, evaluators need to know the strengths and weaknesses of various methodologies (designs, measures, data analysis techniques). This is essential to selecting appropriate methods and in utilizing findings.

Third, techniques exist which can enhance the likelihood that evaluation findings will be utilized. Evaluators need to be aware of these techniques and assume the responsibility for applying them.

In addition to these needs, there has been and remains pressure from many sources (taxpayers, Federal and State agencies, legislators) for more effective evaluation in all the human services. Drug abuse prevention, because of its recent emergence as a human service field, is especially in need of effective evaluation in order to demonstrate the importance of adequately funding programs and projects. In part because of this pressure, people in the field are especially receptive to efforts to improve the quality of evaluations.

The Guidelines addresses the above concepts, so important to the effectiveness of drug abuse prevention evaluations. One objective of the Guidelines is to provide a broad survey of evaluation technology so as to acquaint evaluators and their customers with the range of options available, and thus aid them in securing the required information efficiently and effectively. Another objective is to increase the ability of evaluators to recognize both the usefulness and limitations of their findings. The results of even the most sophisticated research are likely to have some limitations, which the user must be aware of in order to make reliable use of the information. Toward this end, the Guidelines will review the principal and approaches for dealing with each type of bias. Where a critical bias has not been controlled for, or a significant systematic error weakens a result, the Guidelines will point out what limited use can be made of the flawed results.

With respect to utilization, the Guidelines takes the position that it is the evaluator's responsibility to increase the likelihood that new knowledge will be applied by decision makers. Evaluators must do what they can, within reason, to encourage their customers to use the results. Elsewhere in the Guidelines are detailed procedures for implementing evaluation findings.

The Guidelines model is not a logical theory of evaluation; it attempts rather to organize information concerning evaluation into a particular framework. This framework is designed to be sufficiently specific to guide evaluators in the conduct of effective and useful evaluations yet flexible enough to encourage incorporation of new developments in prevention programming and evaluation technology.

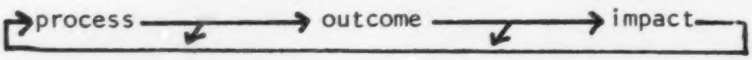
EVALUATION PARAMETERS

The Guidelines proposes three major parameters of evaluation. This organization is appropriate for evaluation regardless of the point at which formal evaluation activities are begun. The three parameters are: levels of program evaluation, type of evaluation information, and target area.

LEVELS OF PROGRAM EVALUATION

The levels of evaluaton refer to the successive stages in the development of information in an ideal evaluation effort. This can be represented in the following systems diagram:

Figure 3. Evaluation Levels



Process Level

Process information reflects the inputs that go into a program, the patterns in which these inputs interact, and the transactions that take place within the program. Information such as participant and staff characteristics, physical plant characteristics, and financial resources, as well as the theory on which the program operates, needs assessment, policy development, and program design activities are all examples of program inputs. Information derived from the sociopolitical environment is also considered to be important evaluative information because of its potential contribution to subsequent evaluation and its use as a basis for record keeping systems. Other assessments on the process level may include a description of services rendered, the decision-making structure, patterns of interaction among participants and staff, and so on.

Outcome Level

Data gathered during this phase of program evaluation typically are addressed to specific program objectives concerned with change in participant behavior, attitudes, values, or knowledge. The major objectives in all prevention program modalities concern the reduction of inappropriate drug and alcohol use. At the same time, different prevention programs have unique objectives relating to the particular theories underlying them. These include such diverse objectives as improvement of of self-concept and responsibility, reduction of alienation, increase in achievement motivation, and improvement in a broad range of variables relating to school performance. And this list is far from exhaustive.

Impact Level

Information gathered in this phase relates to longer-term, generalized results of program operations. The manner in which impact data are relayed is a function of the community needs and problems which gave rise to the prevention program in the first place. That is why such broad issues as changes in incidence and prevalence in drug abuse and in community competence to deal with these problems are frequently addressed in impact evaluation. Such changes impinge directly on the inputs to the program.

INFORMATION TYPE

The Guidelines identifies three types of evaluation information: descriptive, associative, and explanatory.

Descriptive data are the easiest to obtain and frequently can be taken from program records. However, program records often are inadequate. Therefore one of the first contributions of an evaluation effort to a program may be the development of a better record keeping system. But then, development of a management information system comprised of descriptive data categories is a perfectly legitimate byproduct of an evaluation.

Associative data relate variables thought to significantly effect program functioning without assigning causality. Obtaining associative data usually requires more elaborate evaluation design, more time, more cost, more justification to management than obtaining descriptive data.

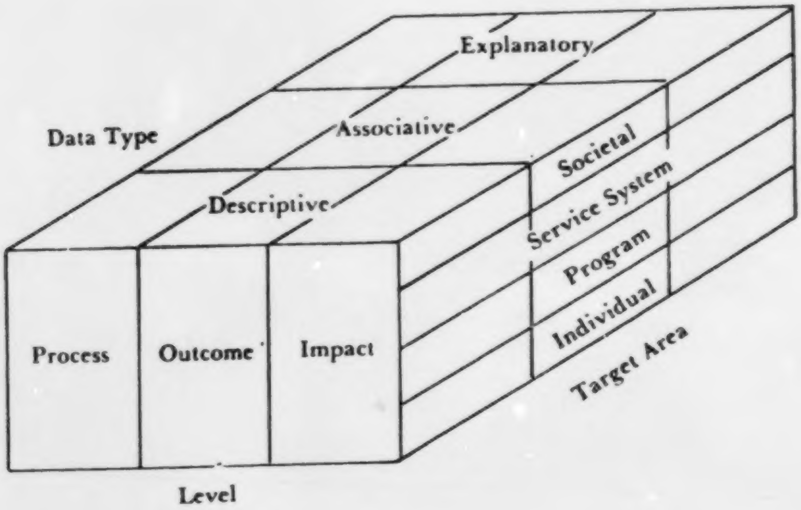
Explanatory data attempt to answer the question "why?" The rationale for development of this type of data requires still more sophisticated design, theory testing, and basic knowledge building than for associative data.

TARGET AREA

Maintaining a systems oriented focus, it is important to realize that evaluation can be directed at different targets or subsystems of the overall program. The level of focus can influence significantly the type of question asked. The most common targets of analysis are an individual, face to face group, program, service system area, and, finally, components of the general society. The well-publicized success or, more realistically, the failure of one individual in one program can have significant repercussions throughout the system and may influence policy at the societal level. Conversely, a decision at a high level can dramatically influence the behavior of individuals in local programs.

Figure 4, is a matrix of the parameters discussed on the preceding pages. It attempts to depict the possible interactions between, and combinations of, level, type of information, and target area of evaluation. The matrix is presented to illustrate that there is a potential for meaningful analysis within each cell. However, some cells are infrequently, if ever, found in evaluations. The choice of cells in any particular evaluation depends upon the needs of decision makers and the availability of resources.

Figure 4. Matrix of Evaluation Parameters



SYSTEMS CHANGE USING EVALUATION: PROGRAM DEVELOPMENT

Properly employed, evaluation ensures that program development will be a rational process, one based on the constant supply and assessment of feedback to programs. It follows that the maximum potential effectiveness of evaluation will be realized if evaluation has a role from the first stages of program development. But in reality, actual introduction of an evaluation into a program can occur anytime in a program's life, and the point at which it is introduced has implications for the type of feedback. For example, planning or initiating evaluation in the earliest phases of program development may encourage collection of data concerning activities that simply may not be recordable later.

Given the link between program development and evaluation, it is useful to examine five major phases of program development and the evaluation issues associated with each. The phases are listed below:

- Needs assessment
- Policy development
- Program design
- Program initiation
- Program operation.

The first three phases may be considered planning operations, whereas the last two are implementation activities. A similar classification will be used in the discussion of the process of evaluation. Each phase has associated with it a major issue for program evaluation that may not be explored or even understood if the evaluation is not introduced until sustained program operation is achieved. A brief discussion of these phases and their associated evaluation issues follows.

The needs assessment phase of program development is a planning activity which attempts to establish whether and to what extent certain previously defined problems and needs exist in a community and which subgroups are affected. The major issue for program evaluation at this point is one of external validity. That is, program ineffectivemess can result from incorrect assessment of the problem. Specifically, the evaluator must realize that no matter what program is eventually put into operation, it should have a valid needs assessment as its foundation.

The policy development phase establishes the goals and specific objectives for the local intervention or program area. The issue for evaluation here is one of construct validity. In this instance, either the causal theory may be inappropriate or it can be improperly translated into policy (that is, improper translation into independent or dependent variables). There may not have been, for instance, appropriate understanding and consideration given to certain community values and other critical factors in the socio-political environment.

The program design phase involves transforming policy into significant characteristics of the program (for example, the target population, personnel qualifications, intervention methods, and other program aspects). Again, evaluators must be aware of a construct validity issue. Program policy may be appropriate, but the program itself fail because of an improper translation of policy.

The program initiation phase calls for the translation of theory into action. It is then that the program is implemented. Many evaluation practitioners believe that it is in this phase that program evaluation data collection first takes place. In other words, there is a difference between the evaluation that takes place during needs assessment, that which takes place during policy development or analysis, and that which begins with the implementation of program activity. The focus of evaluation in the program initiation phase is on the identification of participants, resources, and constraints. The major issue for evaluation at this time is one of external validity. Program design may be appropriate, but the program still fail due to improper implementation of the design.

The program operations phase involves those critically important internal transactions which are a major focus of management information systems. The predominant issue for evaluation activity during this "process" phase is one of internal validity. Program implementation (initiation) may be appropriate, but the program may fail anyway because of faulty management (for example, high staff turnover and insufficient supervision).

The major issue for evaluation in relation to program results, both outcome and impact, is one of conclusion validity. Program operations may be appropriate, but failure still result from the influence of external factors. In addition, throughout all five phases of program development, statistical conclusion validity is an issue--it may lead to unclear or misinterpreted outcome or impact data.

EVALUATION PLAN

These Guidelines are based on the proposition that any assessment of program value must be made in the context of community need and alternative strategies for meeting those needs. The ideal evaluation activity is as responsive as possible to the socio-political environment surrounding the program activity, as well as to the needs of a broad range of decision makers.

The ideal evaluation plan[1] is seen as consisting of nine sets of activities, each of which builds on preceding activities. Feedback to decision makers and evaluators, and consequently utilization of results, can occur from any activity and thereby provide for continuous modification of program and evaluation activities. (See Figure 5.)

The basic premise in the implementation of the evaluation plan is that chances for an effective and useful evaluation to occur are maximized when a skilled evaluator works in a cooperative fashion with an equally skilled program staff member. A collaboration of this sort stands to produce an evaluation plan that is sensitive to the heart of the program under study.

The evaluation activities are listed below in the order in which they normally occur:

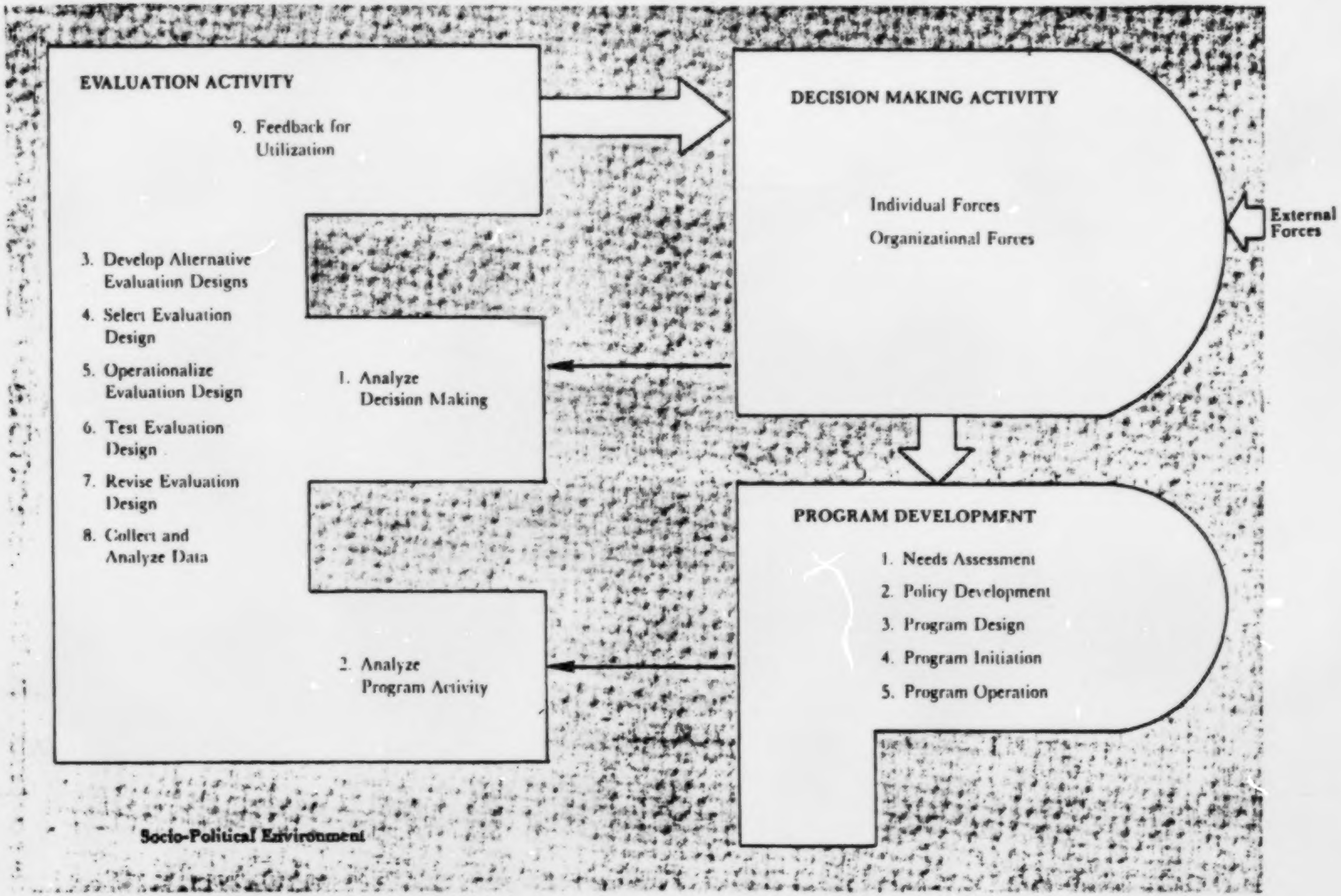
1. Analysis of decision-making activities
2. Analysis of actual or intended program activities
3. Development of alternative evaluation designs
4. Initial selection of a design
5. Operationalization of the design
6. Field test of the evaluation plan or revisions of the plan
7. Revisions resulting from the field test
8. Collection and analysis of data
9. Utilization of information resulting from interpretation of collected and analyzed data.

ANALYSIS OF DECISION-MAKING ACTIVITY

Ideally, the objectives or purposes of an evaluation will determine the type and amount of information to be collected and analyzed, as well as the appropriate uses that can be made of evaluation results. The NPERN model stresses that these objectives or purposes should be related to the needs of the users. Thus, the first step in the evaluation process is to identify the primary users and assess their needs, for example, their requirement for information relating to specific decision-making activities.

Next, the evaluator and the decision maker should specify the kinds of information or indicators that are relevant for the decision-making activity and the amount and detail of information that is necessary. It can be assumed that there will be a tendency to over-identify information "needs." Thus, the next component in this task is to differentiate information that is desirable from that which is essential. One

Figure 5. The (Ideal) Evaluation Plan


EVALUATION ACTIVITY
9. Feedback for Utilization
3. Develop Alternative Evaluation Designs
4. Select Evaluation Design
5. Operationalize Evaluation Design
6. Test Evaluation Design
7. Revise Evaluation Design
8. Collect and Analyze Data
1. Analyze Decision Making
2. Analyze Program Activity
DECISION MAKING ACTIVITY
Individual Forces
Organizational Forces
External Forces
PROGRAM DEVELOPMENT
1. Needs Assessment
2. Policy Development
3. Program Design
4. Program Initiation
5. Program Operation
Socio-Political Environment

way to do this is to assess the expected impact of the information, or its absence, on decision-making and program activities.

A final step involves determining the quality of data that will be acceptable to and used by the decision maker. Quality of data is controlled by the evaluation design, measurement procedures, and analytical procedures. The question is whether or not the decision maker will use information collected within a quasi-experimental design, using qualitative assessment techniques, or whether s/he will accept only data gathered within a true experimental design.

ANALYSIS OF PROGRAM ACTIVITY

An effective evaluation requires a program that has: (1) testable program assumptions, (2) clearly specified and measurable objectives, and (3) documented program strategies. Collaboration of program personnel and evaluators in the analysis of program activity substantially increases the possibility that the program will meet these requirements and that there will be a commitment to use the results.

The analysis of program activity, coupled with a study of decision making, provides the information needed by an evaluator to develop alternative designs. The analysis seeks to identify basic characteristics of the processes of the program, and its operating relationship to the ideals of planners, legislators, and others. Opinions and values may be challenged and revisions may be required.

The conceptual basis of the program should be clearly understood. This includes the assumptions or hypotheses on which the program is based and the rationale for the modalities in effect. The evaluator should know what the assumed dependent and independent variables are, and how the various program strategies are intended to effect the changes identifed in the objectives.

Program objectives should be stated in terms of changes that are being sought; what degree, extent, or pattern of changes, in quantifiable terms, is being sought; how the changes will be measured or indicated; and the time frame in which the objectives are expected to be achieved.

The documentation of program processes or activities is important to the evaluator because of the implications they have for certain dimensions of evaluation. Program recruitment, referral, or intake procedures all shape the design to be used in a program evaluation. The manner in which services are delivered, let alone the objectives and the content of the service, can affect the type and timing of measurement and the unit to be measured, as well as the costs and quality of data. The development and the maintenance of a good record system is one way that a program can ready itself to contribute to effective evaluation. Design and establishment of a data base that provides an accurate picture of a program's inputs and processes should be one of the first steps taken in an evaluation effort. Such data are most useful in planning the evaluation.

DEVELOPMENT OF ALTERNATIVE EVALUATION DESIGNS

The preceding activities provide the information needed to design a feasible evaluation plan. Many texts on evaluation research stress the need for evaluation research to model itself along the lines of classical experimental designs. While such designs have an important role in outcome and impact evaluation, they are of limited use in process evaluations. Furthermore, there are alternative approaches to evaluation that may make important contributions to decision-making and may be more appropriate than the classical approach, given time and resource constraints or the dynamics of the program being considered.

Designing an evaluation requires that choices be made carefully among information options, which are themselves subject to time and resource constraints. Ideally, the evaluator should prepare several workable evaluation plans that will meet the identified needs of the decision maker. The plans will likely vary as to the following: type of information (explanatory, descriptive, associative); timing of measurements (including both frequencies and intervals); measurement techniques (interview/questionnaire, observation, archival); qualitative versus quantitative assessments; single versus multiple measures; and--obviously--who and what is measured. At issue is the quantity and quality of information to be produced and the costs associated with each. Many drug abuse prevention projects are funded for less than $50,000 per year, and this must cover the cost of an evaluation as well as the expense of operations. A project of this scale usually can afford to spend at most $2,500 to $5,000 on an evaluation. However, such projects also may be able to contribute staff hours and time of the administrator. Despite financial limitations, evaluators should be able to assist such a project, perhaps by obtaining the bulk of the desired information from relatively simple descriptive statistics and using carefully chosen variables.

INITIAL SELECTION OF AN EVALUATION DESIGN

To enable the decision maker to make an informed choice among alternative plans, the evaluator should rank the plans according to criteria relating to the decision maker's needs identified in step one (for example, the level of confidence associated with each design, resources required, and other advantages and limitations). This process may result in changes in previously identified needs and considerations so that additional design development may be necessary. In effect, the development-selection processes may require several iterations until an initial, feasible evaluation plan is selected.

PUTTING THE EVALUATION DESIGN INTO AN OPERATION CONTEXT

Having selected an evaluation design, the evaluator and program personnel will "operationalize" the plan. Instruments need to be selected or developed, and design elements of sampling, data collection, data analysis, and utilization procedures specified and incorporated into a time frame. Appropriate roles for evaluators and program personnel are also spelled out.

One strategy for ensuring that an evaluation is intimately tied to project development and that the results are understood and utilized by decision makers working with the project, is to build an active role for project personnel in the evaluation. The role of project staff can vary greatly. They may conduct the actual evaluation, with occasional help from an outside consultant, or they may only provide research assistants to perform low-level tasks, with the major work being done by the outside evaluator.

The role of the evaluation consultant too may vary. In some cases it will correspond to that of the independent evaluator. Where the project staff assume a primary role in the evaluation process, the evaluator may function as a guide or resource person--s/he may introduce appropriate technical options and help with the design of the evaluation and the selection among alternatives. S/he may also provide training and technical assistance to enhance or complement the skills of the project evaluation staff.

FIELD TEST OF THE EVALUATION PLAN

All aspects of the evaluation plan should be pilot tested, including sampling, data collection and analysis, dissemination, and utilization. The pilot test should determine whether the data collection schedule is feasible, if the collection can be carried out with minimal disruption to program activities, if the data being collected are valid, whether the variables are reliably measured, if the costs of data collection and analysis are on target, and whether the resulting information is used as intended by the decision maker.

REVISE EVALUATION DESIGN

Following the field test, evaluators and program personnel should review the plan and its initial operation to determine what, if any, revisions should be made and what procedures should be followed to implement the full scale evaluation.

ROUTINE DATA COLLECTION AND ANALYSIS

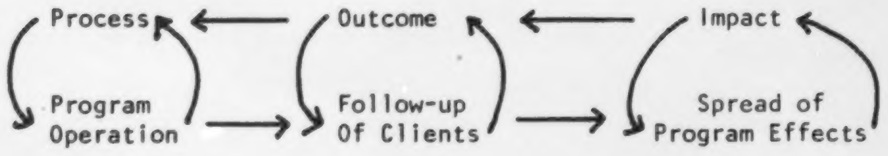
Implementation of the evaluation process on a full scale requires routinized data collection and analysis. As ideally envisioned in this model, data will be produced and interpreted in a scheduled series of oral and written reports, along with special reporting as required. It should be noted that during this stage of the evaluation process the preceding evaluation activities may be continued or repeated. This is a major feature of the incremental evaluation process--learning is open ended and no "step" is ever completed.

UTILIZATION

The evaluation cycle is completed with the feedback and utilization of results from routinized data collection and analysis. Utilization is the final test of any evaluation model. In most of the social services, the history of program evaluations is characterized by scant use in decision making at any level. The field of drug abuse prevention is no exception. Although no systematic analysis has been performed to explore the reasons for this failure, it is commonly assumed that a major cause relates to unmet expectations of the decision makers for whom the studies were intended. The evaluation model recommended in these "Guidelines"--a feedback system at its heart--stresses that the ultimate decision makers should be involved early on in the design of the evaluation, thereby ensuring that their expectations will be addressed, if not satisfied. Evaluations that provide periodic feedback in the form of reports that include quantitative data are especially well-suited for this purpose. In addition, the decision maker who helps design the data presentation will be more likely to accept data-based implications.

Feedback loops are one of the distinguishing features of evaluation. Tehrefore, the pattern and function of feedback loops should be designed or negotiated in advance. Figure 6 portrays a typical feedback loop system for different levels of evaluation.

Figure 6. Evaluation Feedback Loops



The assumption behind a feedback system planned to facilitate program improvement is that the elements and timing of the critical points in the loop should be predetermined to the extent possible. Furthermore, the potential implications of possible negative findings from alternative courses of action should be outlined.

Figure 7 illustrates a feedback loop system for selected elements of an evaluation in which client characteristics affect staff selection, and staff characteristics have implications for client recruiting. Staff inputs in turn will influence training practices, and so on down the line. Ultimately, all of these affect the program services which, upon observation and evaluation, may have implications for client recruitment, staff selection, and staff training.

If evaluation results are to be utilized, the organization for which the results are intended must have an internal climate that is receptive to new information. The evaluator therefore has the responsibility to try to develop a climate of receptivity within the receiving organization. This does not mean that the evaluator must be a full-fledged organizational developer capable of transforming an organization that is dead set against incorporating his/her work. It does mean that on a limited scale the evaluator is expected to look for ways of improving the climate for the utilization of the evaluation findings.

A multiplicity of organizational levels usually surround a particular prevention program, and should be taken into consideration when planning an evaluation. The model is intended to help the administrators and evaluators appreciate the variety of uses that can be made of the evaluation results if it is planned and designed properly. Modifications in design and activities may occur in subsequent cycles of the process, thus encouraging the use of the findings by decision makers at alternative levels.

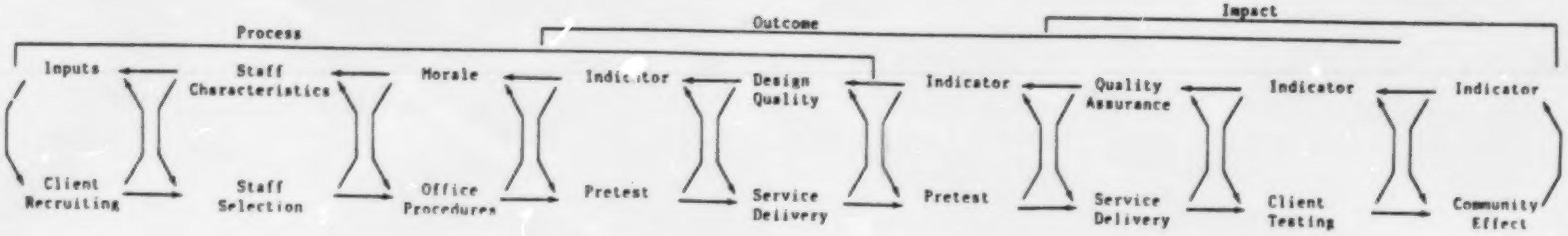
DECISION-MAKING ACTIVITY

The evaluator must keep in mind that in addition to the evaluation results themselves, there are a host of other forces which affect decision making. Often these other factors are more influential than evaluation findings. There are the by-products of the socio-economic milieu in which decisions are made.

These forces can be categorized in terms of how they relate to the individual decision maker, and to influences inside and outside the organization. (Overlaps obviously exist between these categories.)

Individual forces. The personality and leadership style of decision makers have major impact on the way evaluation findings are accepted. His/her perception of how the organization will accept particular findings, his/her commitment to change both in a general sense and as regards the particular problems addressed by the evaluation, and the persuasiveness which the decision maker brings to the organization all affect an evaluation's potential to bring about change.

Figure 7. Process, Outcome, and Impact Feedback Loop Overlap


Process
Outcome
Impact
Inputs
Client Recruiting
Staff Characteristics
Staff Selection
Morale
Office Procedures
Indicator
Pretest
Design Quality
Service Delivery
Indicator
Pretest
Quality Assurance
Service Delivery
Indicator
Client Testing
Indicator
Community Effect

Organizational forces. Not only are the invividual characteristics of the decision maker important but just as salient are the ways in which s/he is viewed by others within the organization. The perceived power and credibility of the decision maker, stemming from professional authority and personal prestige, will influence the extent to which evaluation findings will be accepted and implemented.

External forces. Extra-organizational forces--essentially those of the community and of funding sources--as well as the general belief system of the prevention field have powerful influences on the degree to which evaluation findings are accepted. Community action can support or hinder program change; inaction on the part of the community reflects a lack of interest, a desire to maintain the status quo, or simply poor community organization directed at the problem area. Obviously, the relative importance of drug abuse prevention as a community issue will have a strong effect on how evaluation findings will be received and acted upon within both the community and the organization.

A full discussion of leadership styles and their effect on organizations may be found in Cartwright and Zander (1968), while a comprehensive discussion of the utilization of knowledge, including annotated bibliographies, may be found in *Putting Knowledge to Use* (Glaser and Davis 1976). The topic of utilizing evaluation findings and the role of the evaluator in this process is more fully discussed in Chapter 10.

CONCLUSION

The model presents a framework for improving the quality of evaluations. The nucleus of the model is *program evolution*--a continual search for alternative ways of achieving a specific objective, facilitated by a feedback or monitoring device, with mechanisms for correction. The likelihood of producing an effective and useful evaluation is increased when a skilled evaluator works cooperatively with an equally skilled prevention professional. Thus, prevention evaluation should be a *multifaceted*, *incremental*, and *iterative* process.

ENDNOTES

[1] This approach borrows heavily from: John D. Waller and John W. Scanlon. "The Urban Institute Plan for the Design of an Evaluation." Working paper 3-003-1. Washington, D.C.: The Urban Institute, March 1973. (Copies may be obtained for either author at the Performance Development Institute, 1800 M. St., N.W., Suite 1025-South, Washington, D.C. 20036).

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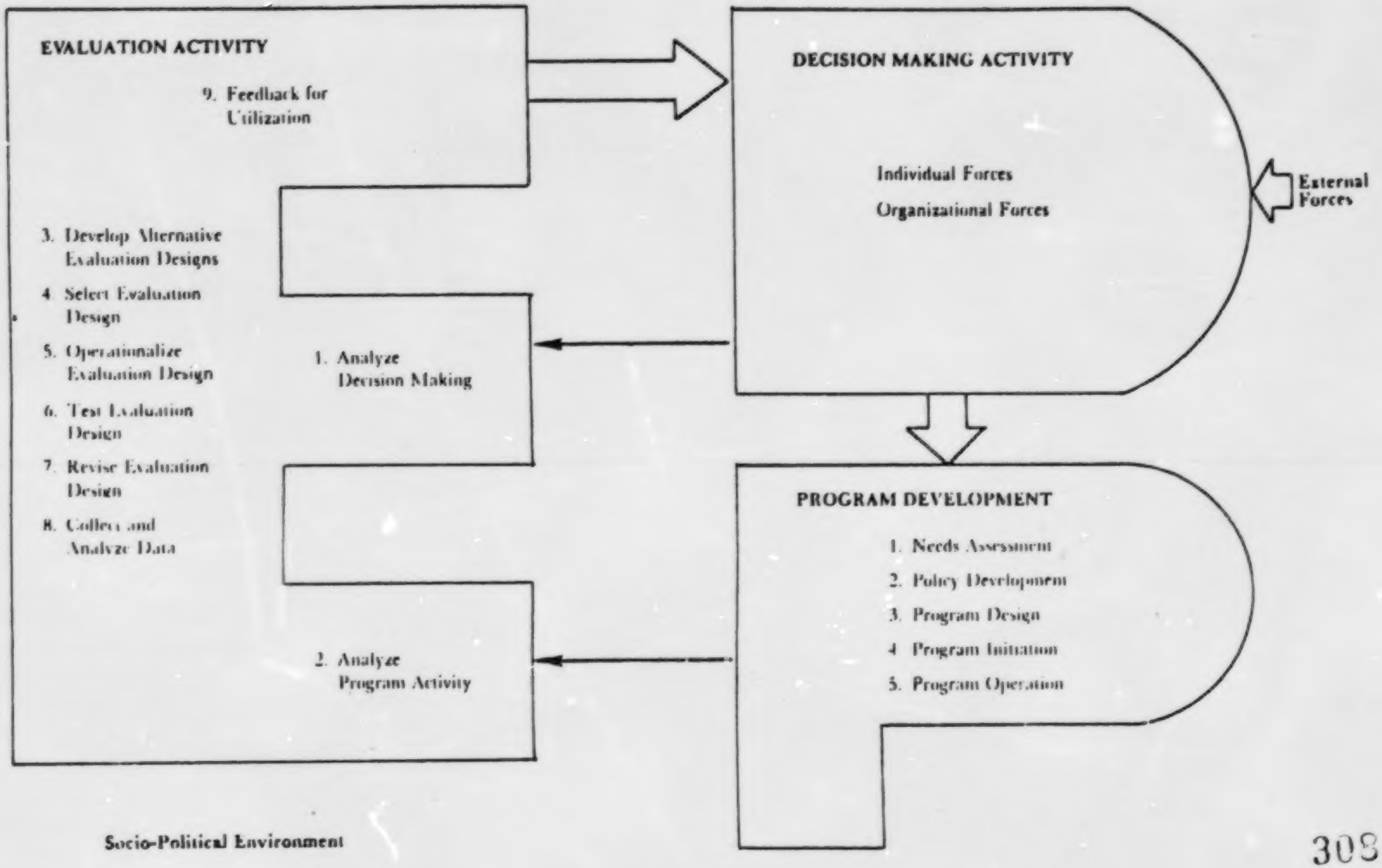
Figure 5. The (Ideal) Evaluation Plan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PROGRAM DEVELOPMENT
1. Needs Assessment
2. Policy Development
3. Program Design
4. Program Initiation
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Socio-Political Environment

Primary Prevention Evaluation Research

A Review of 127 Program Evaluations*

Prepared by

Eric Schaps, Ph.D.

Carol S. Palley, B.A.

Shoshanna Churgin, M.P.H.

PYRAMID PROJECT

Pacific Institute for Research and Evaluation

Walnut Creek, California

February, 1980

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XII. CONCLUSIONS AND RECOMMENDATIONS

The picture painted in this review of prevention program effectiveness is tentatively encouraging. It should be remembered, however, that primary prevention impact research remains very weak in general, and very large gaps remain in the research literature. Neither overall evaluation quality nor intensity of evaluated service programs has improved much over the last ten years. Only a small number of credible evaluations has been successfully implemented.

Perhaps the most important findings of this review are those emanating from the analysis of eight exemplary impact studies. These were the studies which coupled the most intensive programming with the most rigorous evaluation. One of the eight evaluated a drug information-only program and showed that program to be somewhat counter-productive. The remaining seven studies assessed affective interventions either alone or in combination with other strategies. Six of the seven showed positive drug-specific outcomes (the seventh produced no effect) and the five which measured various ancillary outcomes showed all of these to be positive as well. Thus, taken together, the most credible and ambitious of the reviewed studies suggest that the "new generation" of programs may help to prevent drug abuse problems.

Some supporting evidence, but extremely weak and assailable evidence, for the efficacy of prevention programs comes from the overall analyses of drug-specific outcomes presented in earlier sections (e.g., Tables 26, 31), which show slight positive effects when outcome ratings for all programs were averaged.

The positive findings notwithstanding, we feel that the quality of impact data in primary prevention is still far from adequate for guiding policy formulation and program development. Much of the available data come from studies which are poorly designed or conducted (i.e., no control groups, retrospective data, small samples, etc.). Often the data are inappropriately analyzed. Usually the data are incompletely and unsystematically reported. There are now a few impact studies of which the field can boast, but far too few for policy makers and program developers to rely upon when charting general directions and designing specific approaches.

GENERAL RECOMMENDATIONS

We recommend that prevention professionals encourage rigorous outcome evaluation of programs wherever appropriate. All levels of government should encourage comparative research designs when providing funds to well established prevention efforts, and should provide the substantial funding needed to implement such designs. In funding new programs, however, formal outcome evaluation is probably premature, and intensive formative evaluation spanning a period of several years is likely to be more productive.

We also recommend the establishment of an active, well-publicized repository for the collection and dissemination of program evaluation reports. Regular updating and re-analysis of the impact literature along the lines of the current effort is also needed, so that eventually more conclusive statements can be made about the results of particular types of drug abuse prevention efforts.

Another high priority should be greater and more systematic evaluation of prevention programs oriented to minority group populations and sub-populations. Many of the evaluations we reviewed were of programs serving largely majority group populations, and not enough studies of differential program effects on minority groups have been conducted.

RECOMMENDATIONS FOR PROGRAM PLANNING

When planning prevention efforts, careful consideration should be given to the scope, intensity and duration of program services. It seems plausible that programs of low scope, intensity and duration will have smaller effects than more ambitious efforts, but this hypothesis has not been systematically tested, and nothing is known about optimally cost-effective levels of service intensity.

Planners should encourage the development of prevention programs impacting minority populations, and other special groups (elderly, women, etc.).

Greater use of parents and peers as primary service delivery agents should be carefully considered.

Programs which only provide pharmacological or legal information about drugs should generally be avoided.

RECOMMENDATIONS FOR PROGRAM EVALUATIONS

One recommendation for improving impact research has not been much discussed in the literature: outcomes must be better linked to actual program events. In the majority of evaluations reviewed here, only a brief, superficial description of the program under study was provided. In a few there was no description at all, only a statement of program goals or intentions. In all but one or two, there was no mention of the source for a program description (e.g., first-hand observation, program records, project funding proposals). Good program descriptions are necessary for the reader to understand the generalizability and import of the findings.

If an evaluation is to be useful internally, as a program management tool, or externally, as a policy making tool, findings must be set within the context of a description of the program as it actually operates. Ideally, this involves a description of the program's setting, history, organizational structure, staffing, and management procedures. The target group should be described with as much demographic information as possible: geographic character (i.e., urban, rural, suburban), socio-economic data, ethnicity, age, etc. This description should include documentation of what actually transpires at the "delivery site," that is, in the classroom, training session, or rap room. Such documentation falls within the realm of process evaluation, and systematic program documentation is necessary for the proper utilization of outcome evaluation data. Without adequate process evaluation, we may be in the awkward position of knowing the effect without knowing the cause.

Greater use of multiple measurement techniques when evaluating prevention programs is desirable. Most of the studies we reviewed gathered data only by questionnaire. Multiple measurements can yield richer data and more conclusive comparisons can be made. Other measurement techniques that can be used are: interviews, teacher or staff reports, archival or institutional records, observations by the evaluators themselves, and physical trace measures (i.e., beer cans, cigarette butts, etc.).

In measuring drug-related outcomes, it is desirable to gather data concerning several facets of the phenomenon, such as actual drug use, intentions to use, and attitudes toward drug use. Further, questions should focus on a variety of specific drugs, both licit and illicit, well defined by explanation and examples. In several of the reports we reviewed, it was unclear if "drugs" meant illicit drugs, licit drugs, or both. The target population must be able to understand the questions asked, and the report reader must be able to interpret the data accurately.

Most measurement schedules should include both pre- and post-tests. We recommend that retrospective-only schedules be avoided, and that post-test only schedules be used only with large, randomly constituted samples (under such circumstances, post-only designs may be preferable to pre-post designs). The timing of the pre- and post-tests should be given careful consideration. If possible, a follow-up wave after the post-test should be conducted to determine the durability of program effects and to detect any delayed effects.

The use of equivalent comparison groups is vital if changes in experimental groups are to be attributed to the program. Ideally, assignment to one group or another should be random, but rigorous quasi-experimental designs are available when random assignment is not possible, or when control groups are simply available.

For more information about program evaluation methods or findings please contact:

PYRAMID
39 Quail Court, Suite 201
Walnut Creek, California 94596

(800) 227-0438 (for out-of-state)

(415) 939-6666

MODULE IX

MODULE IX: PREVENTING BURNOUT **TIME:** 3 HOURS

GOALS

- Make participants aware of the role burnout may play in their efforts to develop community-based prevention programs
- Enable them to develop realistic alternative coping strategies.

OBJECTIVES:

At the end of this module, participants will be able to:

- Identify at least five symptoms of burnout
- Identify at least five causal factors in their own work/life that might lead to burnout
- Identify at least four possible strategies which that might employ to either prevent or alleviate burnout at both a personal and organization level.

MATERIALS:

- Newsprint
- Magic Markers
- Pencils
- Post-test
- Opinionnaire

MODULE IX OVERVIEW

EXERCISE	TIME	METHODOLOGY
1. INTRODUCTION	5 MINUTES	LECTURE
2. IDENTIFYING SYMPTOMS AND CAUSES OF BURNOUT	30 MINUTES	LARGE-GROUP EXERCISE
3. COPING STRATEGIES	15 MINUTES	DISCUSSION
4. WRAP-UP AND REFRESHER	30 MINUTES	DISCUSSION
5. POST-TEST	30 MINUTES	INDIVIDUAL

STAFF BURNOUT AS A FORM OF ECOLOGICAL DYSFUNCTION

JEROME F. X. CARROLL, PH.D.

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STAFF BURNOUT AS A FORM OF ECOLOGICAL DYSFUNCTION

Nearly all of us have either directly experienced "staff burnout" or observed its destructive consequences among our co-workers. What puzzles me so is that we who in the human services field are so well trained to recognize, treat, and prevent the emotional distress of others can be so insensitive and impotent in dealing with staff burnout among ourselves. In theory, you might expect staff burnout to occur less often or in less severe forms in the human services field, because its onset would be recognized sooner and experienced, effective treaters would be readily available to deal with the problem. Yet it is precisely here that the phenomenon occurs in its most virulent forms with distressing frequency and regularity.

My own view of staff burnout is that it is a form of ecological dysfunction since its "pathogenic location"/1/ lies primarily in the interaction between an individual and his work environment, although interactions with other ecosystems or environments also contribute to the extent they too are stressful and frustrate important human needs.

Typically, staff burnout involves a person with inadequate stress management and need-gratifying skills on the one hand, and a very stressful and need-frustrating work environment on the other. While burnout may occur in any line of work, it seems especially likely to occur in work which necessitates attending to and servicing the emotional needs of others.

Various writers, in describing staff burnout, have tended to emphasize either the individual's inadequacies/2/ or environmental sources of stress./3/ Most acknowledge both factors, with various degrees of "tilt" toward one or the other of these two points of emphasis.

Jones, for example, in stressing the individual role, describes staff burnout as "...the condition when you have given all you have and feel you can't give any more; when you have reached the point of frustration where solutions, even imperfect ones, are not presenting themselves; the beginning 'in a rut' state where ideas and solutions are at a standstill, are repetitive and freshness is gone."/4/

Earlier, Maslach had described staff burnout as "...something inside you goes dead, and you don't give a damn anymore"/5/ Ottenberg likened staff burnout to a form of "battle fatigue,"/6/ while Shubin described it as a form of "disillusionment" and "emotional exhaustion" leading to "total disgust with one's self, humanity, everybody."/7/ Pines and Maslach defined staff burnout as"... a syndrome of physical and emotional exhaustion, involving the development of (a) negative self concept, negative job attitudes, and loss of concern and feeling for clients."/8/

Freudenberger assumed a mid-way point between the individual and environment; while concurring that staff burnout means "...to fail, wear out, or become exhausted...inoperative," he also stressed the point that a whole agency can experience burnout and cited numerous environmental conditions that contribute to staff burnout./9/ Morris, in her study of staff burnout, also underscored both individual and environmental factors./10/

White, however, clearly and cogently attends to the environmental side of the equation, noting that "the term 'staff burnout' has been used to describe, in the aggregate, an innumerable list of personal and interpersonal problems that result from continued contact with high stress work environments."/11/ His "systems" approach to burnout focuses on "...the manner in which organizational structures, internal organizational relationships, and the organizational group's relationship with its environment effects the physical and emotional health of individual members."/12/

White also stresses the point that since staff burnout is "an interactional problem," it requires modification of both "...the high stress work environment and the individual victim's style of stress management."/13/

Smits, too, underscores the contribution of problems and inadequacies in the work environment (e.g., inadequate supervision and the failure of organizations to alter their structure and functions to accomodate change) in discussing staff burnout./14/

Symptoms of Staff Burnout

Physical. Among the most common physical symptoms encountered are: feelings of exhaustion and fatigue; being unable to shake a cold; feeling physically run-down; frequent headaches and gastrointestinal disturbances; sudden weight loss or gain; increase in blood pressure; sleeplessness; shortness of breath; and increased susceptibility to various illnesses, including the common cold.

Psychological. Among the more common psychological symptoms of staff burnout are: increased feelings of depression, exhaustion, hopelessness, disillusionment, boredom, being trapped in one's job, helplessness, self-doubt about one's ability to heal (effectiveness) and the value of one's work, isolation (aloneness), not being appreciated for one's hard work and dedication (being taken for granted), or simply being ignored; increased rigidity, stubbornness, and judgmental thinking; hyperirritability and quickness to anger; increased suspiciousness and distrust; loss of one's initial enthusiasm for the job, loss of charisma, and loss of control over the expression of feelings; change from optimism to pessimism, cynicism; change from basic acceptance and respect for clients to rejection and disrespect; change from being a creative, flexible thinker to a mechanical, petty bureaucrat; increased drinking, drug-taking, gambling; diminished control over such basic drives as hunger and sex; and a significant decrease in judgment and reasoning, including the inability to consider the likely consequences of certain acts.

Social. The most commonly observed social symptoms include: a significant decrement in the ability to relate to one's clients as individuals, especially in a constructive, friendly, and caring manner; people in treatment begin to be responded to in terms of labels or categories (e.g., the "fractured tibia in room 203" or the "D&A case that Murphy's treating"); generally withdrawing and isolating oneself from others; overbonding with other staff members, that is, seeking to satisfy one's most basic human needs (e.g., recognition, friendship, love, and sex) almost exclusively through contacts with one's co-workers; the severing of long-term relationships (e.g., through divorce); increased sexual promiscuity; increased interpersonal conflicts, both on the job and at home; centering one's life around the job (e.g., by working an inordinate number of overtime hours and then "justifying" this behavior as a form of "dedication" to one's work and a reflection of just how "important" one is to the organization): just hanging around the institution after normal work hours, with no special purpose; and taking repeated risks that endanger one's physical and psychological health.

Systems symptoms. Among the more common systems symptoms associated with staff burnout are: first and foremost, a significant decrement in the quality of services provided to clients occurs, even though the organization's statistical reports may continue to "look good" or even "improve"; subsystems (e.g., divisions, departments, offices) increasingly interrelate in a distrusting, competitive, and hostile manner; bureaucratic "turf" becomes increasingly sharply defined and jealously guarded; authority conflicts emerge more frequently and with greater rancor; important organizational decisions are more frequently decided by an increasingly isolated, elitist group which, less and less, seeks meaningful input from lower-level staff; communications within the system are poor; and humanistic, friendly, and informal staff encounters are increasingly replaced by stereotyped fixed-role, formal, but "quite proper," staff interactions.

Other signs of staff burnout within the system include: poor staff morale, as evidenced by workers and management expressing increased feelings of mutual disrespect and distrust that may lead to both sides insisting that their respective rights, responsibilities, and relationships be legally codified; staff members arriving late or failing to show up for important meetings and appointments; and management spending more and more time away from the organization and otherwise reducing the amount of time it spends in direct contact with line staff.

Still other systems symptoms include: increased absenteeism, especially sick leave; higher staff turnover and a decrease in average length of stay on the job; fewer staff leave the organization amicably due to an increase in firings and/or forced resignations; assigning additional work responsibilities (e.g., administrative paperwork) without adequate compensation in pay and/or reduction of the existing workload; a salary structure and benefits package that is well below that available at other nearby organizations offering similar services; an inadequate or unreliable funding source (e.g., one which can not even permit annual salary increments to stay even with the annual rate of inflation); and worsening relationships between the organization and other human services delivery systems, funding sources, regulatory agencies, legislative bodies, boards and surrounding communities.

Who is Most Susceptible

There seems to be general agreement that the most susceptible people to experience staff burnout are those human services providers who: (1) work in a highly stressful work environment, especially one which requires that the human services provider work intensely and intimately (emotionally), over an extended period of time, with very needy, demanding, despairing, alienated, economically poor, politically powerless, and highly traumatized clients; and (2) those, who for many reasons (some conscious and rational, others unconscious and irrational), invest heavily in their personal self on the job--the "dedicated" or "committed" worker. Those who in Freudenberger's words, tend to "...take on too much, for too long, and too intensely."/15/

While burnout seems to claim an inordinate number of those who provide direct services to clients, it also occurs among administrative staff as well. Furthermore, as Freudenberger has observed, it is also possible for an entire organization to experience burnout./16/

In discussing susceptibility to burnout, only M.L. Jones thought to call attention to one of the largest groups of human services providers most susceptible to "staff" burnout: housewives./17/ Too often when the problem of staff burnout is considered, we tend to overlook those not working in formally designated mental health and rehabilitative facilities, e.g., housewives.

Presumed Causes

The pathogenic location of staff burnout already has been identified as lying in the *interaction* between the individual and his/her ecosystems, especially his/her work environment. The etiology of this form of ecological dysfunction, therefore, can be expressed by the formula S.B.=f(I×E), i.e., staff burnout (S.B.) is a function of (f) the dynamic interaction of many factors, both intrapsychic (I) and extrapsychic (E). Since this perspective implicitly rejects any overly simplified, single-factor explanations of burnout, its adoption lessens the likelihood that one would fall prey to "blaming the victim,"/18/ i.e., explaining burnout solely on the basis of the individual's alleged inadequacies.

Individual factors. Beginning with the individual (I) component of the formula, any and all factors or combination of factors within the "internal environment" or person that militate against performing his/her job under stress should be considered. All physical illnesses that lower the individual's energy level, strength, and resistance to stress would also be considered, as would all earned maladaptive behavior patterns (e.g., phobias, character disorders, alcoholism, excessive gambling, etc.) that have the same effect.

Inadequate education and training to do the job also constitute major personal factors contributing to staff burnout. Individuals with limited job knowledge and skills are especially vulnerable to burnout, since they must continually confront problems with which they are ill prepared to cope. They are also likely to feel "trapped in their jobs," since their present skills and knowledge do not qualify them for advancement.

The same can be said for those with limited insight. Such persons are likely to mismanage the dual problems of transference and countertransference commonly encountered by all human services providers. This usually results in therapeutic failure for the client and defeat for the service provider.

Examples include the individual, who because he/she expects and fears rejection from others, withdraws and/or seldom communicates his/her needs to others--this individual must live with an unremitting, desperate need for love, attention, and respect from others which usually means he/she will typically find it difficult to say no to others and/or let his/her clients go once treatment is completed.

Other examples include: a compulsive need to make retribution for past wrongs, typically associated with unnecessary and exaggerated personal sacrifices for the alleged benefits of others; overidentifying with clients to the point of losing the basic ability to judge the rightness or wrongness of clents' behaviors; or, conversely, expressing just barely concealed contempt and hostility for the perceived inferiority of clients whose problems are very similar to those of the human services provider.

Perhaps the most damaging of all the dynamics associated with a negative self-concept is the inability or refusal of the insecure human service provider to seek assistance from others. As the demands of his/her job increase and stress mounts, this worker, fearing that his/her hidden inadequacies will soon surface for everyone to see and ridicule, has only one option; that is to redouble already over-extended efforts to get the job done. More often than not, this last gasp effort will fail, leaving the worker with but one thing to do--burnout.

Paradoxically and tragically, this inability to admit to personal limitations and seek assistance from others will not usually be seen as an irrational act. More often than not, it is viewed as a sign of "true dedication to one's job." Rather than getting help, the worker will usually be given the equivalent of "tea and sympathy"--a palliative treatment at best.

Systems factors. Systems factors contributing to staff burnout may be grouped into three categories: those inherent in the job itself; those associated with the work environment; and those in the other ecosystems or environments that impinge upon the worker.

With respect to the first category, it is generally acknowledged that those aiding people, especially the poor, who have "failed" to successfully adjust to society's model of "normality" (e.g., those working in state mental hospitals, prisons, the welfare system, remedial educational programs, etc.) have received minimal support from society. Thus public, as opposed to private treatment facilities are nearly always distinguished by overworked and undercompensated staff. In addition, clients finding their way into the public sector of the human services delivery system are typically afflicted with the most extreme forms of disability (e.g., the rate of schizophrenia is nearly always greater at public mental health treatment centers than at private facilities located in the same geographical area).

Thus the public service worker in the human sector is given the dubious task of healing the most disabled, powerless, and alienated members of our society. As a consequence, "treatment failure" is commonplace, and this repeated experience is a major contributor to staff burnout.

Another factor inherent in the work of the human services provider which often contributes to staff burnout is the use of staff under enormous internal and external pressure. The former stems from constantly having to examine one's motives and actions to insure that one is behaving in a "correct and proper" manner, while the latter comes from the unending scrutiny of clients who demand that those "who talk the talk, walk the walk," or in other words, practice what they preach. These two unremitting pressures have contributed mightily to staff burnout nearly everywhere such modeling occurs.

Still another inherent factor contributing to staff burnout is the constant demand that they provide their clients with a high degree of presence, caring and healing. Day in and day out, human services workers are expected to fully attend to their clients' needs; hang on every word and gesture in order to discern cognitive and emotional meaning; offer unqualified respect and support, and most importantly, friendship and genuine concern. This constant "being there" and giving to others, especially very needy others, will eventually exhaust any worker's capacity to continue giving. Without some form of replenishment, the worker's diminishing ability to attend and to give to others is bound to lead to feelings of guilt (because "professionals" are supposed to be able to go on giving forever) and anger (When am I going to get mine?).

The second category of systems factors would include such items as the failure of the organization to attract and hire fully qualified people to do a job or to provide effective education, training, and supervision. Other illustrations of factors within this category include creating a work environment fraught with competition, distrust, nonsupport (both emotional and financial), and poor communications. The lack of opportunities for advancement within an organization, arbitrary and biased promotions and demotions, the exercise of dictatorial or elitist powers, and the failure to coordinate and integrate the work done by various components or subsystems within the organization constitute other examples in this category.

The third category pertains to other ecosystems which create their own adjustment demands and thereby help to overload the individual's stress management system. Included here are deteriorating relationships at home with one's companion and/or children; neighborhood problems (e.g., higher real estate taxes, vandalism, and theft); high rates of inflation and unemployment; natural catastrophies; racism, sexism, and other "isms"; problems at school; being moved to a new area, away from old friends and relatives; and loss of people within the individual's social network (e.g., due to death, divorce).

Treatment

Interventions that focus on the individual. Perhaps the most immediate need for the staff member suffering from staff burnout is relief from stresses on the job. This can be done in many ways (e.g., giving the person time off away from the institution, assignment to a different and hopefully less stressful job within the organization, or allowing other staff to pick up some of the person's workload). It is most important that supervisory staff insure that the person being granted time off not view this action as a form of weakness or failure; the same is true for the person's co-workers. If other staff are asked to pick up some of the burned out staff member's workload, they must be helped to do this in a cooperative, positive manner.

The importance of good physical health should not be overlooked in treating staff burnout. It is advisable to have a very thorough physical examination as well as personal counseling, in view of the destructive role of a negative self-concept in staff burnout. Therapeutic modalities that focus on stress management (e.g., relaxation therapy, desensitization, biofeedback, meditation, yoga, and assertiveness training) could be especially helpful. On the other hand, very stressful therapeutic modalities (e.g., marathon or encounter groups) should be avoided./19/

Additional education and training may also be beneficial, especially in conjunction with removal of the person from his/her immediate job situation. In pursuing this, a careful inventory of the staff member's training needs is vital and should address such areas as: expectations, values, and standards which the staff member is using to judge performance of duties (e.g., they may be unrealistically high); whether or not the person knows how to maintain a healthy and constructive distance in working with clients; and the ability of the worker to prepare written reports (many have never been adequately trained to cope with administrative paperwork).

Burned out staff members should also carefully and objectively examine sources of stress and sources of potential support or need gratification; they could then be helped to develop better stress management techniques and to more effectively seek and obtain the support and need gratification they need.

Treatment aimed at the work environment. The treatment of staff burnout entails making changes in the structure, policies, and operating procedures of the organization in order to mitigate or eliminate stresses emanating from the work environment.

White has identified a number of interventions, including: improving hiring procedures and on-the-job training; providing adequate nurturing of staff through such means as granting guilt-free time out periods, job changes, and recognition for personal effort; providing carefully graduated levels of responsibility for new staff; obtaining training outside the agency or from nonagency staff; encouraging and assisting staff to identify and achieve career goals and objectives; preventing the same individuals from always working overtime; insuring that staff are adequately compensated for their work, and if their workload is increased, increase salaries and/or decrease other aspects of the workload; and, for paraprofessionals who had been patients, formally marking their change in status from patient to staff./20/

It was Freudenberger,/21/ however, who suggested the ultimate intervention. When and if the organization as a whole showed signs of being burned out, he recommended closing down the facility for a period of time. Although at first glance this recommendation seems rather extreme, there are many ways this could be done and still satisfy minimal patient-care requirements for funding purposes. For example, the facility could host an activities day or an organizational shut down--at least in terms of business as usual.

Treatment for the nonwork ecosystems. Treatment directed toward nonwork ecosystems is much more difficult and risky to implement, but nonetheless important to attempt. If, for example, a major source of stress is the individual's homelife, the work agency could either offer the worker and his/her family marital counseling or refer them to an appropriate treatment facility, preferably with some financial assistance to defer costs.

Although no agency can single-handedly overcome societal "isms," each organization can do its very best to confront racism, sexism, "ageism," etc. as each of these social dynamics operates within its own system. Cleaning up one's own work environment strengthens the resolve of people to cope with "isms" in other ecosystems.

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Prevention

As Smits remarked, "prevention is probably easier than treatment" where staff burnout is concerned./22/ In order to design an effective prevention program for staff burnout, however, it is essential to maintain the ecological dysfunction perspective. Staff burnout prevention programs that ignore the environment or the interaction between the individual and his/her environment will most likely result in failure. Prevention programs, therefore, must be multifaceted and address all of the components in the formula, S.B.=f(IxE).

The individual. With respect to the individual, Freudenberger,/23/ Jones,/24/ and Shubin/25/ advocated regular physical exercise as a means of maintaining one's health and ridding oneself of excess tensions and stress. Jones also underscored the importance of using such relaxation techniques as biofeedback to prevent a build up of tension and stress./26/

The value of training human services providers to effectively structure their time, both on the job and off, was also emphasized by Jones./27/ White expressed similar thoughts on the need to develop an ability to organize one's work in order to avoid overextending oneself on the job./28/ Along these lines, a number of writers stressed the importance of learning to set realistic goals, expectations, and limits for the job./29/

Ottenberg/30/ and Shubin/31/ stress the need for human services providers to learn the art of maintaining some distance between themselves and their clients while simultaneously responding in a personal manner to clients as individuals. Freudenberger/32/ expressed similar thoughts when he advised workers to be more cautious, self-protective and attentive to their own needs.

Replenishment. Teaching staff how to identify and better use their resources, strengths, and potentials is another effective prevention strategy to counter staff burnout. This approach is based on the work of Herbert Otto and his students, who developed numerous, creative group exercises designed to promote human growth and development./33/ I have used these exercises with human services providers to replenish that vital source of energy which permits them to continue to discern and respond to the desperate needs of their clients.

Too often in their jobs, human services providers are taken for granted; that is, they are expected to stand fast in a sea of turmoil, suffering, and pathos because they are "professionals." Their assignment is simple: give of yourself, over, and over, and over again.

Unless the person assigned the healing, nurturing role receives the same care and attention he/she so generously extends to those in need, sooner or later, that healer will falter and suffer burnout. Unfortunately supervisors of professionals seldom give as much attention to the art of "stroking" as they do to the art of criticizing someone's mistakes or shortcomings. Thus, human services providers are likely to be understroked and overstressed on their jobs.

For these reasons, I have developed a small group, weekend workshop program for human services providers to satisfy their basic need for recognition, concern, warmth, and acceptance--to replenish that healing energy force which they continually tap in meeting clients' needs. Since their giving to clients is social in nature, so, too, their taking must be social, hence the use of small groups. As they give to their clients, so too they must receive recognition, acceptance, and concern from others without having to be anything but themselves.

Assisting people to get in touch with their inner resources, strengths, potentials, and beauty in a social setting marked by a high degree of acceptance, genuine concern, and sharing has tremendous healing properties. It replenishes and constitutes a powerful prophylactic against burnout.

The work environment. Nearly everyone agrees that strict limits must be placed on the number of hours staff can work in a program, and these limits must be rigorously enforced. Periodically rotating staff from high stress to low stress jobs and providing guilt-free time away from the job also have been advocated by nearly everyone writing about staff burnout.

Pines and Maslach offered the following recommendations: reduce the patient-to-staff ratio; shorten work hours by creating a shorter work shift, with more breaks; establish more part-time positions; allow more opportunities for time outs; and share the patient load, especially with respect to more difficult patients (e.g., those with multiple substance abuse problems and serious psychopathology as well)./34/

Pines and Maslach also recommend changing the function of staff meetings to permit staff to socialize informally and confer about problems, clarify goals, etc.; improving work relationships by developing support systems for staff; holding retreats for staff members (preferably away from the work site) where they can discuss their feelings about themselves, their patients, and the organization; training staff to become more aware of work stresses and to recognize signs of impending staff burnout, and to seek help; and more realistically training staff as to what to expect in their work./35/

White also directly addresses systems issues in discussing the prevention of burnout. He recommends: not adding more work unless additional compensation is given; obtaining outside consultations to guard against the stifling effects of ideological incest; encouragement of continuing education for the staff; and the development of formal rituals which permit the expression of affection among workers, especially those leaving the organization./36/

He also stresses/37/ the need to deal with nonwork relationships and activities that have a detrimental effect upon a person's work and/or the work environment of the agency; the need to prevent scapegoating of certain staff members; and the need to periodically reasses programs, policies, and practices (also advocated by John W. Gardner, in a different context),/38/ especially as people leave the organization.

Freudenberger recommended more careful selection of volunteers and a greater willingness to use volunteers to reduce the workload; training staff to recognize the difference between being overly dedicated vs. realistically dedicated; preventing staff from drifting apart and isolating themselves when they are most stressed and in need of support; and assisting overstressed administrators to learn to delegate responsibilities and functions, as well as to share their feelings (especially their negative feelings) with other staff./39/

Conclusion

Staff burnout must be viewed as stemming from the interaction of both debilitating individual and environmental factors which together detract from the person's ability to do his work. Treatment and prevention must be approached from many directions and at various level, hopefully, in a coordinated and well-integrated fashion. Staff burnout, simply stated, is not an individual disease. It is an ecological dysfunction and must be dealt with as such.

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5. C. Maslach, "Burned-Out," 5 *Human Behavior* 16-22 (1976).

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10. T. Morris, "Is Staff Burn-Out Occurring at the Partial Hospitalization Gateway?" unpublished paper, December 1978.

11. White, *supra* note 3a, at 4.

12. Id. at 6.

13. White, *supra* note 3b, at 1.

14. S.J. Smits, "Beyond 'Burnout,'" 3 *Journal of Rehabilitation Administration* 2-3 (1979).

15. Freudenberger, *supra* note 9.

16. Id.

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18. W. Ryan, *Blaming the Victim* (New York: Pantheon, 1971).

19. Freudenberger, supra note 9.

20. White, supra note 3.

21. Freudenberger, supra note 9.

22. Smits, supra note 14.

23. Freudenberger, supra note 9.

24. Jones, supra note 2.

25. Shubin, supra note 7.

26. Jones, supra note 2.

27. Id.

28. White, supra note 3.

29. Freudenberger, supra note 9.

30. Ottenberg, supra note 6.

31. Shubin, supra note 7.

32. Freudenberger, supra note 9.

33. H.A. Otto, "Toward a Holistic Treatment Plan," in H. Greenwald (ed.), Active Psychotherapy (Chicago: Aldine, 1967); H.A. Otto and J. Mann (eds.), Ways of Growth (New York: Grossman, 1968); H.A. Otto, Group Methods to Actualize Human Potential (Beverly Hills, Calif.: The Holistic Press, 1970).

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35. Id.

36. White, supra note 3.

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38. J.W. Gardner, "Continuous Renewal: Best Route to Orderly Social Change?" The Philadelphia Inquirer, Dec. 15, 1968, at section 7, p.1.

39. Freudenberger, supra note 9.

COMMUNITY-BASED PREVENTION SPECIALIST

Pre/Post-Test

Instructions: You have approximately 30 minutes to complete this assessment. Please read all questions carefully. So that learning gain can be measured from the beginning of the course to the end, please put your name on the assessment form.

NAME: ______________________________

AGENCY: ______________________________

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Instructions: The following are true/false questions. Record your answer by circling the letter representing your response. Circle T for true, F for false.

1. T F Formal communication networks include key people, highly visable people, groups, and agencies within the community which can be used to disseminate information regarding drug abuse prevention activities and programs.

2. T F Burnout refers to the rate of attrition among people who are actively engaged in working with other human beings with personal, emotional, or psychic distress.

3. T F The concept of prevention was first developed in the field of preventive medicine.

4. T F As part of the prevention planning process, problem statements are generated as a result of determining the philosophy of prevention, determining the role of the SSA, analyzing legal mandates, and a survey of problem behavior indicators.

5. T F Pharmaceutical psychoactive drugs are more commonly used than black-market substances.

6. T F Primary prevention activities are directed toward those who have not had a problem with their drug use and those who have had a chemical use problem but have never been deemed appropriate for chemical dependence treatment.

7. T F Factual information on drugs deters and prevents drug use abuse.

8. T F Action planning serves to provide a framework for effecting change in a program's structure, process, and/or function.

9. T F It is important to plan for evaluation of your prevention program once it has become operational.

10. T F The Prevention Planning Model begins with an assessment of needs, includes the analysis of resources needed for tasks, and culminates with a determination of plan feasibility.

11. T F Primary prevention can increase the probability of early identification of various drug problems.

12. T F Although every community should provide education, it need not provide acculturation for its newcomers (e.g., children, immigrants).

13. T F Functional areas of a community include home, school, church, roadways, and parks.

14. T F Classifying drugs as "legal" and "illegal" has contributed to effective social and political drug policies.

15. T F To be effective in minimizing drug use problems, prevention programs need to address existing community societal problems.

16. T F Psychoactive drugs change the minds or moods of people who take them.

17. T F Few communities plan at the outset for the variety of social and health service programs that are needed.

18. T F Building community support is the primary factor for realizing prevention program objectives.

19. T F Psychoactive drug use was accelerated when chemists began to create synthetic substances.

20. T F In preparing a prevention program objective, the planner should consider whether the objective is consistent with organizational goals and whether the outcome of the objective is worth the time and effort required to achieve it.

Instructions: The following are multiple-choice items. For each item, circle the letter representing the best answer.

21. According to Klein, which of the following is NOT a function of a community?

    1. Providing sanitary waste disposal for its members.

    2. Creating and enforcing rules and standards of belief and behavior.

    3. Transmitting information, ideas, and beliefs.

    4. Making available the means for distribution of necessary goods and services.

22. NIDA's drug abuse prevention activities include which of the following models?

    1. Alternatives to drug use.

    2. Education programs.

    3. Media-based information/education campaigns.

    4. Intervention programs.

        a. 1, 2, and 4
        b. 1, 2, and 3
        c. 1 only
        d. all of the above

23. Which statement is NOT a reason why prevention efforts were initiated.

1. Reduce demand for drugs.
2. Reduce costs associated with drug abuse.
3. Reduce drug usage by white middle-class youth.
4. Reduce supply of drugs.

24. Which of the following is NOT a revolution which gave rise to acceptable drug-taking behavior?

1. Taking drugs to alter the body for our convenience and pleasure.
2. Taking drugs to cure the body of addictive dependencies.
3. Taking drugs to cure diseases of the body.
4. Taking drugs to cure diseases of the mind.

25. Which of the following represents the principal target group for prevention efforts?

1. Social/recreational users.
2. Non-users.
3. Experimenters.
4. Circumstantial users.

a. 1, 3, and 4
b. 1, 2, and 3
c. 1, 2, and 4
d. 1, 2, 3 and 4

26. The "high-risk" individual shows significant inadequacies in which of the following areas?

1. Identification with viable role models.
2. Intra-personal skills
3. Inter-personal skills
4. Religious values

a. 1, 3, and 4
b. 2, 2, and 3
c. 1, 2, and 4
d. 2, 3, and 4
e. all of the above

27. In multicultural prevention planning, which of the following are important components?

1. Space relations

2. Racial/ethnic/cultural identification

3. Norms

4. Socio-economic status

   a. 1, 2, and 3
   b. 2 and 4
   c. 1, 3, and 4
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28. Types of networks include which of the following?

1. Peer Network

2. Person-family Network

3. Organizational Network

4. Human Service Networks

5. Interorganizational Networks

   a. 1, 2, and 3
   b. 3 and 5
   c. 2, 3, 4 and 5
   d. 2 and 4
   e. all of the above

29. Which of the following statements are true when referring to how a community might react to change?

1. Resistence to change increases in proportion to the degree in which it is perceived as a threat.

2. Resistence to change decreases when it is perceived as being favored by trusted others, such as high-prestige figures.

3. Commitment to change increases when those involved have the opportunity to participate in the decision to make the change and its implementation.

4. Resistence to change decreases when the change is sudden and brought about by the use of direct pressure.

   a. 1 and 2 only
   b. 2 and 3 only
   c. 1, 3 and 4
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30. The compulsive drug user is characterized by all but which of the following?

1. A high degree of psychological dependence.
2. Motivated by the user's perceived need to achieve a new effect in order to cope with a specific problem situation.
3. Preoccupation with drug taking precludes other social functioning.
4. The process of securing drugs interferes with essential activites.
5. None the above.

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